CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-10 Medicare Quality Improvement Organization	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 32	**Date: April 12, 2019**
	Change Request 11206

SUBJECT: Update to Publication (Pub.) 100-10 to Provide Language-Only Changes for the New Medicare Card Project

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update Pub. 100-10 with the New Medicare Card Project-related language. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

EFFECTIVE DATE: May 13, 2019
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 13, 2019

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	5/5040.1/Beneficiary Complaint: Preparing and Forwarding the Medicare Quality of Care Complaint Form
R	5/Appendix 5-1.1/Medicare Quality of Care Complaint Form
R	5/Appendix 5-1.3/Quality Review Decision (QRD) Form
R	5/Appendix 5-2/Beneficiary Quality of Care Complaint: Initial Acknowledgement Letter to Beneficiary/Beneficiary Representative
R	5/Appendix 5-3/Beneficiary Quality of Care Complaint: Interim Determination Letter for Practitioners and Providers
R	5/Appendix 5-4/Final Initial Determination Letter to Practitioners/Providers with Request to Disclose (For Beneficiary Complaints)
R	5/Appendix 5-4.1/Beneficiary Quality of Care Complaint: Final Determination Letter to Practitioners and Providers
R	5/Appendix 5-4.2/Beneficiary Quality of Care Complaint: Final Determination Letter to Beneficiary/ Beneficiary Representative
R	5/Appendix 5-5/Re-Review Determination Letter to Providers/Practitioners with Request to Disclose (For Beneficiary Complaints)
R	5/Appendix 5-5.1/Beneficiary Quality of Care Complaint: Reconsideration Determination Letter to Practitioners and Providers
R	5/Appendix 5-5.2/Beneficiary Quality of Care Complaint: Reconsideration Determination Letter to Beneficiary/Beneficiary Representative
R	5/Appendix 5-6/General Quality of Care Reviews - Initial Determination Letter with Right to Request Reconsideration to Practitioners and Providers
R	5/Appendix 5-7/General Quality of Care Reviews: Final Reconsideration Determination Letter to Practitioners and Providers
R	5/Appendix 5-8/REQUEST FOR QIO REVIEW FORM
R	7/7115/Content of Denial Notice
R	7/7220/Basic Elements for Quality Concern Notices
R	7/7430/Reconsideration Process
R	7/7440/Circumvention of Prospective Payment System (PPS)
R	7/7520/Assembling the Hearing Claim File
R	7/Exhibit 7-23/Record Not Submitted Timely Denial Model Notice
R	7/Exhibit 7-24/Billing Error Denial Model Notice
R	7/Exhibit 7-25/Preadmission Denial Model Notice
R	7/Exhibit 7-26/Admission Denial Model Notices
R	7/Exhibit 7-27/Continued-stay Denial Notices

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	7/Exhibit 7-28/Procedure Denial Model Notices
R	7/Exhibit 29/Day Outlier Denial Model Notice
R	7/Exhibit 7-30/Cost Outlier Denial Model Notices
R	7/Exhibit 7-31/DRG Changes as a Result of DRG Validation Model Notice
R	7/Exhibit 7-32/Outpatient/Ambulatory Surgery Denial Model Notices
R	7/Exhibit 7-33/Continued-stay Denial Completed Notice
R	7/Exhibit 7-34/Circumvention of Prospective Payment System (PPS) Denial Model Notice
R	7/Exhibit 7-40/Reconsideration Notices -- Hearings Model Paragraphs
R	7/Exhibit 7-41/Reconsideration Model Notice -- Preadmission Denial
R	7/Exhibit 7-42/Reconsideration Model Notice -- Admission Denial
R	7/Exhibit 7-43/Reconsideration Model Notice -- Continued-stay Denial
R	7/Exhibit 7-44/Reconsideration Model Notice -- Procedure Denial
R	7/Exhibit 7-45/Reconsideration Model Notice -- Day Outlier Denial
R	7/Exhibit 7-46/Reconsideration Model Notice -- Cost Outlier Denial
R	7/Exhibit 7-47/Re-review Model Notice -- DRG Changes as a Result of DRG Validation
R	7/Exhibit 7-48/Reconsideration Model Notice -- Outpatient/Ambulatory Surgery Denial
R	7/Exhibit 7-49/Reconsideration Completed Notice -- Continued-stay Denial
R	7/Exhibit 7-50/Reconsideration Model Notice -- Circumvention of Prospective Payment System (PPS)
R	7/Exhibit 7-71/Potential Quality Concern Model Notice
R	7/Exhibit 7-72/Confirmed Quality Concern Model Notice
R	7/Exhibit 7-73/Re-review Upheld Quality Concern Model Notice
R	13/13110/QIO Review Documentation

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-10	Transmittal: 32	Date: April 12, 2019	Change Request: 11206

SUBJECT: Update to Publication (Pub.) 100-10 to Provide Language-Only Changes for the New Medicare Card Project

EFFECTIVE DATE: May 13, 2019

**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: May 13, 2019

I. GENERAL INFORMATION

A. Background: The CMS is implementing changes to remove the Social Security Number (SSN) from the Medicare card. A new number, called the Medicare Beneficiary Identifier (MBI), will be assigned to all Medicare beneficiaries. This CR contains language-only changes for updating the New Medicare Card Project language related to the MBI in Pub. 100-10.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires removal of the SSN-based Health Insurance Claim Number (HICN) from Medicare cards within four years of enactment. There are no new coverage policies, payment policies, or codes introduced in this transmittal. Specific policy changes and related business requirements have been announced previously in various communications.

B. Policy: MACRA of 2015.

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
11206.1	Contractors shall be aware of the updated language for the New Medicare Card Project in Pub. 100-10.	X	X	X	X					QIO

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	None					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kim Davis, 410-786-4721 or kimberly.davis@cms.hhs.gov , Tracey Mackey, 410-786-5736 or Tracey.Mackey@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 0

5040.1 – Beneficiary Complaint: Preparing and Forwarding the Medicare Quality of Care Complaint Form

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

After ending the intake call described in §5030.2, the QIO should immediately input basic information obtained during the phone call into the Medicare Quality of Care Complaint Form, except in situations where the beneficiary has requested that the form be emailed or in situations where the beneficiary expressed desire to complete the form himself or herself.

NOTE: A QIO must protect confidential information under 42 CFR §480. Confidential information communicated between the QIO and the beneficiary must only be transmitted via a secure electronic submission to ensure appropriate protection of the information. Confidential information includes Personally Identifiable Information (PII) and information that would be Protected Health Information (PHI) under the HIPAA Privacy and Security Rules (45 CFR Parts 160 and 164) if the information is from a covered entity (health plan or health care provider) or if the QIO were a covered entity.

A QIO is prohibited from using any independently developed complaint forms. A QIO may only use the official Medicare Quality of Care Compliant Form (CMS 10287).

The QIO may direct the beneficiary to the QIO's website or the CMS forms web page to obtain a copy of the Medicare Quality of Care Complaint Form. To assist the beneficiary in completing the Medicare Quality of Care Complaint Form, the QIO should pre-fill the following sections of the form with the information provided by the beneficiary before mailing or faxing it to the beneficiary:

1. The beneficiary's name;

2. The beneficiary's Medicare *beneficiary identifier*;

3. The beneficiary's sex and age (if known);

4. The beneficiary's race/ethnicity (if the respondent is willing to provide it);

5. The name of the beneficiary's authorized representative (if someone other than the beneficiary will be the contact);

6. The pertinent contact information, including street address and phone numbers for either the beneficiary or representative; and

7. A brief description of the complaint following the requirements of §5030.1.

NOTE: The QIO can send the beneficiary complaint form by mail, fax, or email from the time the information is collected.

NOTE: When the beneficiary requests the form to be sent via email, the QIO must not pre-fill the form in order to assure confidentiality. When sending the complaint form by fax, the QIO should ensure that the beneficiary is aware that the fax is being sent and that it will contain confidential information. The QIO must comply with requests from the beneficiary to not pre-fill the complaint form.
Prohibition against Forwarding Additional Information: The Medicare Quality of Care Complaint Form and the Appointment of Representative Form are the only forms identified by CMS for use in the Beneficiary Complaint Review process. The QIO may forward a cover letter explaining the complaint process and any instructions for the complaint process. The QIO should not forward any additional information to the beneficiary. The QIO may only mail, fax, or email the Medicare Quality of Care Complaint Form and the Appointment of Representative Form (Appendix 5-1.2), if applicable (See the discussion of this Appointment Form in the note below).

For a copy of the Medicare Quality of Care Complaint Form, see Appendix 5-1.1, "Medicare Quality of Care Complaint Form and Instructions" or visit http://www.cms.hhs.gov/cmsforms/downloads/cms10287.pdf.

For a copy of the Appointment of Representative form, see Appendix 5-1.2, or visit http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf .

NOTE: When a Beneficiary Representative contacts the QIO to file a complaint on behalf of a beneficiary, the QIO must question the beneficiary representative about his/her status as a "representative" of the beneficiary in order to establish that the representative has the authority to file a complaint and to receive confidential information.

Return of Completed Medicare Quality of Care Complaint Form and/or the Appointment of Representative Form:

- In situations where the beneficiary or beneficiary representative requests to return the completed forms by email to the QIO's email address, the beneficiary must be advised that while returning the completed form by email is an option, the QIO is not responsible for the privacy of the beneficiary's private health information and that doing so may not offer adequate security for protected health information.

NOTE: Emailed forms or facsimiles are deemed "written" for purposes of receipt of a signed written beneficiary complaint. (See §5040.3.)

Appendix 5-1.1 – Medicare Quality of Care Complaint Form

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Medicare QUALITY OF CARE COMPLAINT FORM

Information to Help You Fill Out the "Quality of Care Complaint" Form

The Medicare Program works to ensure that beneficiaries get the best care possible. We take your concern(s) seriously, and we would like to get more information to help us review your request. Use of this form will ensure that we process your concerns in an efficient manner. Quality Improvement Organizations (QIOs), are under contract with Medicare and are required to conduct reviews of all written complaints from beneficiaries about the quality of services not meeting professionally recognized standards of health care. You may contact the QIO for assistance in completing this form or for general assistance regarding your complaint.

Please use this step-by-step instruction sheet when completing your "Quality of Care Complaint" Form. Be sure to complete all sections of the form. In addition, if your personal information has been included in the form based on contact you have had with the QIO for your State, please review the information to confirm its accuracy.

1. Print the name of the Medicare beneficiary who has a complaint about the quality of health care he/she received.

2. Include the *b*eneficiary's Medicare *beneficiary identifier* if known.

3. Check the appropriate box designating the sex of the individual listed in number 1. In addition, please indicate the age of the beneficiary in the blank space provided, if known.

4. Check the appropriate box or boxes indicating the race/ethnicity of the individual listed in number 1. Please note that this information is strictly voluntary and has no impact on the processing of the complaint.

5. Print the name of the beneficiary's authorized representative if someone other than the beneficiary will be the contact for the processing of the complaint.

6. Print the contact information for the beneficiary or for the beneficiary's authorized representative who is authorized to be the contact for the processing of the complaint.

7. Provide a brief description of the incident or concern. The description should include any information you believe is relevant to the review of your complaint, including:

    - Dates and times,

- Identification of physicians and provider staff involved,
- Information from witnesses if available, and
- A description of what happened; and
- If you require more space to describe your complaint, you may attach additional sheets of paper and you may provide any documents you believe support your complaint.

PLEASE NOTE: If you raise concerns that are not quality of care concerns within the scope of the QIO's authority, your complaint will be referred to the appropriate entity.

1. By signing the form, you are authorizing the QIO to review your complaint and render a formal determination. The processing of your complaint may require requesting and reviewing of pertinent medical records.

2. PLEASE keep this page for your information. Only mail the second page (Medicare Quality of Care Complaint Form) to the QIO. The phone number of your QIO is _______________. A decision on your complaint will be made within ___ days of receiving the signed complaint form.

Form CMS-10287 (Revised 07/14)

<table>
<tr><th colspan="3">MEDICARE QUALITY OF CARE COMPLAINT FORM</th></tr>
<tr><td colspan="3">1. Beneficiary Name:</td></tr>
<tr><td colspan="3">2. Medicare beneficiary identifier:</td></tr>
<tr><td colspan="3">3. Sex: Male__ Female__ Age: ____ Date of Birth:_____</td></tr>
<tr><td colspan="3">4. Race/Ethnicity (Completion of this section is <u>voluntary</u>): How would you describe your race? Please mark one or more boxes. American Indian or Alaska Native___ Native Hawaiian or Other Pacific Islander __ White__ Asian __ Black or African American__ Hispanic or Latino___</td></tr>
<tr><td colspan="3">5. Beneficiary's Authorized Representative's Name (If applicable):</td></tr>
<tr><td colspan="3">6. Contact Information:</td></tr>
<tr><td colspan="3">Street/Apt.</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td>Phone:</td><td colspan="2">Alternate Phone:</td></tr>
<tr><td colspan="3">7. Briefly Describe the incident or your concerns: Include dates and times, persons involved, and description of what happened. Include attachments, if appropriate.</td></tr>
</table>

8. May we reveal your identity during the review of your complaint? Yes__ No __ If you check "no" we cannot review your complaint as a written beneficiary complaint. However, based on the circumstances of your complaint, we may choose to review your complaint as a general quality of care review. You will not receive any information or notice about a general quality of care review if the QIO chooses to perform one.	
9. Check "yes" here if you authorize the QIO to forward your address or other contact information to the entity that conducts beneficiary satisfaction surveys. If you check "yes", you will be contacted by telephone or postal mail to conduct a brief survey about your satisfaction with the service you received from the QIO. **If you leave this question blank, a surveyor will contact you about your satisfaction.** Yes___ No___	
For your information: If you have any questions about your complaint, please call _________________. You will be contacted within ___ days upon the QIO's receipt of the signed complaint form. The QIO will use a physician who practices in the same or similar clinical area as the physician who provided your care in completing its review. You may provide any information you believe is relevant to your complaint, including copies of documentation, names of witnesses, etc. A decision will be made on your complaint within ___ days of receiving the signed complaint form. If your complaint includes concerns not within the scope of the QIO's authority, the concerns will be referred to the appropriate entity.	
10. By signing this form, I am requesting that the QIO review my complaint.	
Signature of Beneficiary/Representative:	Date:
According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1102. The time required to prepare and distribute this collection is 10 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850	

Form CMS-10287 (Revised 07/14)

Appendix 5-1.3 – Quality Review Decision (QRD) Form

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Quality Review Decision (QRD) Form

Case Summary

Case ID#: State: Choose a State

Patient Details

Patient Name:

Medicare beneficiary identifier:

Date of Birth: Click here to enter a Date of Birth. Date QRD Created: Enter QRD Created date.

Date of Death: Click here to enter a Date of Death.

Beneficiary Point of View:

Health Service Encounter

Provider/Practitioner Name:

Provider CCN: Service Start Date: Click here to enter Service Start Date

Provider/Practitioner NPI: Service End Date: Click here to enter Service End Date.

Reason for Health Service Encounter/Admitting Diagnosis:

Case Summary Notes:

Review Details
Review Analyst:
Review Due Date:

Review Analyst Assessment

Please note that the information below must be prepared for each
Quality of Care (QoC) Concern identified in the complaint

Case ID#:
QoC Concern #:

Concern Summary
Concern Category: ____________________
Improvement may be needed in: _________
Quality of Care Concern

Identified by:

Source:

Practitioners involved:
Name: NPI:

Relevant Standard of Care:

Standard of Care Category:
Standard of Care Source:
Standard of Care Publication Date:

Additional Information:

Initial Determination Peer Review

Case ID#: QoC Concern #:

Conclusion:

☐Standard of Care Met

☐Standard of Care Not Met

- ☐Grossly and flagrantly violated the obligation in §1156(a)(2) of the Act, in one or more instances, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)
- ☐Failed in a substantial number of cases (more than three) to substantially comply with the obligation in §1156(a)(2) of the Act, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)
- ☐Substantial failure to comply with the obligation in §1156(a)(2) of the Act to provide care that is of a quality that meets professionally recognized standards (Quality Improvement Initiative recommended; consider referral for technical assistance with QII)
- ☐Significant concern (Quality Improvement Initiative recommended; consider referral for technical assistance with QII)
- ☐Non-significant concern (Quality Improvement Initiative recommended; QIO to consider offering advice or an alternative approach or education)

Agree with QIO Identified Standard of Care:

☐ Agree

☐ Do Not Agree

☐ Concern Identified by IDPR

Reason for Disagreement: **Relevant Standard of Care:**

Standard of Care Category:
Standard of Care Source:
Standard of Care Date:

Rationale/Justification:

Conflict of Interest Statement:
I do not have a material, professional, familial, or financial conflict of interest regarding any parties associated with this case including any referring entity, any health benefits plan, the patient or his/her family, the care providers, the facility, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended (prescribed) or provided; nor have I accepted compensation for my independent review activities that is dependent in any way on the specific outcome of the case or had involvement with the case prior to its referral to independent review.
Initial Determination Peer Reviewer Name (print)**:**
____
Initial Determination Peer Reviewer Signature:
____
Date: **Minutes Spent on Case**:

Final Initial Determination Peer Review

Case ID#:
QoC Concern #:

Written Response Received from practitioner and/or provider:

Relationship of Information to Standard of Care:

Conclusion:
☐Standard of Care Met
☐Standard of Care Not Met
- ☐Grossly and flagrantly violated the obligation in §1156(a)(2) of the Act, in one or more instances, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)
- ☐Failed in a substantial number of cases (more than three) to substantially comply with the obligation in §1156(a)(2) of the Act, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)
- ☐Substantial failure to comply with the obligation in §1156(a)(2) of the Act to provide care that is of a quality that meets professionally recognized standards (Quality

Improvement Initiative recommended; consider referral for technical assistance with QII)

☐Significant concern (Quality Improvement Initiative recommended; consider referral for technical assistance with QII)

☐Non-significant concern (Quality Improvement Initiative recommended; QIO to consider offering advice or an alternative approach or education)

Rationale/Justification:

Conflict of Interest Statement:

I do not have a material, professional, familial, or financial conflict of interest regarding any parties associated with this case including any referring entity, any health benefits plan, the patient or his/her family, the care providers, the facility, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended (prescribed) or provided; nor have I accepted compensation for my independent review activities that is dependent in any way on the specific outcome of the case or had involvement with the case prior to its referral to independent review.

Initial Determination Peer Reviewer Name: ____

Initial Determination Peer Reviewer Signature: ____

Date: **Minutes Spent on Case**:

Reconsideration Peer Review

Case ID#:

QoC Concern #:

Written Reconsideration Request Received from practitioner and/or provider: Click here to enter received date.

Conclusion:

☐Standard of Care Met

☐Standard of Care Not Met

☐Grossly and flagrantly violated the obligation in §1156(a)(2) of the Act, in one or more instances, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)

☐Failed in a substantial number of cases (more than three) to substantially comply with the obligation in §1156(a)(2) of the Act, to provide care that is of a quality that meets professionally recognized standards (Sanction Activity Required)

☐Substantial failure to comply with the obligation in §1156(a)(2) of the Act to provide care that is of a quality that meets professionally recognized standards (Quality Improvement Initiative recommended; consider referral for technical assistance with QII)

☐Significant concern (Quality Improvement Initiative recommended; consider referral for technical assistance with QII)

☐Non-significant concern (Quality Improvement Initiative recommended; QIO to consider offering advice or an alternative approach or education)

Rationale/Justification:

Agree with QIO Identified Standard of Care:

☐ Agree

☐ Do Not Agree

☐ Concern Identified by RPR

Reason for Disagreement: Relevant Standard of Care:

Standard of Care Category:

Standard of Care Source:

Standard of Care Date:

Conflict of Interest Statement:

I do not have a material, professional, familial, or financial conflict of interest regarding any parties associated with this case including any referring entity, any health benefits plan, the patient or his/her family, the care providers, the facility, or the developer or manufacturer of the principal drug, device, procedure, or other therapy being recommended (prescribed) or provided; nor have I accepted compensation for my independent review activities that is dependent in any way on the specific outcome of the case or had involvement with the case prior to its referral to independent review.

Reconsideration Peer Reviewer Name: _______________________________________

Reconsideration Peer Reviewer Signature: ____

Date: _ Minutes Spent on Case: ____

Appendix 5-2 – Beneficiary Quality of Care Complaint: Initial Acknowledgement Letter to Beneficiary/Beneficiary Representative

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIO LETTERHEAD

INITIAL NOTIFICATION

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

Dear [insert name of Beneficiary/ or Representative here]:

We have received your written quality of care complaint(s). Thank you for taking the time to bring your health care concern(s) to our attention.

[Insert QIO name here] is the Beneficiary and Family Centered Care Quality Improvement Organization (QIO) authorized by the Centers for Medicare & Medicaid Services (CMS) to review medical services provided to people with Medicare in [Insert QIO area/region here]. As part of our mission, we review all written complaints about the health care that was provided by a physician and/or facility to people with Medicare. The goal of our review is to determine if that care was appropriate and followed acceptable medical standards. Our review is based on what is written in the medical record but is not limited to your specific complaints. During the review, we may find other concerns about the care you received. You will get our result(s) in writing when the review is completed.

These are examples of the types of factors we can review in a medical record:

- Was your medical condition diagnosed correctly?
- Did you get the right medication for your medical problem?
- Did the doctor perform the right surgery?
- Was the care given to you by the staff done correctly?

Our review process does not address issues such as billing, customer service, communication, legal, or any other issues that are not noted in the medical record. We understand that these issues are important, but our quality of care review is limited to the medical care reflected in the entries in the medical record.

If a quality of care concern is identified, we offer education and feedback to providers to improve the quality of care for people with Medicare. The following is a summary of the concerns identified in your written complaint.

Summary of Concern(s)

What the Medicare Complaint Process **CAN** Address

This first section of the summary letter contains the parts of your complaint(s) that **can** be addressed by a review of the medical record.

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER.

PREPARATION NOTE FOR THE QIO

The summary must include the specific concerns identified by the beneficiary and any concerns identified by the QIO based on the initial intake analysis. (See § 5110.1)

This information should be consistent with the information contained in the QRD Form. (See §5230.2)]

What the Medicare Complaint Process **CANNOT** Address

This second section of the summary letter contains any part of your complaint(s) that may be related to customer service, billing, legal, or other issues that **cannot** be addressed by a review of the medical record.

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER.

PREPARATION NOTE FOR THE QIO

The summary must include the specific concerns identified by the beneficiary and any concerns identified by the QIO based on the initial intake analysis. (See §5110.1)

This information should be consistent with the information contained in the QRD Form. (See §5230.2)]

We want to make sure that we clearly understand your quality of care concerns. **Please feel free to contact us with any questions or comments you may have.**

[Insert QIO Name]
[Insert QIO Contact Person]
[Insert QIO Address]

[Insert QIO Contact Number]
[Insert QIO Fax Number]

It is important to let you know that the actual time needed to complete our review will depend on the time needed to obtain the necessary medical records and responses from the practitioner(s)/provider(s) involved. If there are any delays in the process, we will contact you.

Once again, thank you for bringing your concerns to our attention.

Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-3 – Beneficiary Quality of Care Complaint: Interim Determination Letter for Practitioners and Providers

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

NOTE: This letter is optional since the Interim Determination can be given to Providers/Practitioners via phone and/or in writing. (See §5055.1)

QIO LETTERHEAD

Date of Notice

QIO Liaison for Provider or Practitioner's Name
Name of Addressee
Address
City, State, and Zip Code

Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

Dear: [insert name of Practitioner or Provider here]

The [Insert QIO name here] is the Quality Improvement Organization (QIO) authorized by the Centers for Medicare & Medicaid Services (CMS) to review medical services provided to Medicare beneficiaries in [Insert QIO area/region here]. One of the functions we perform is the review of health care provided to Medicare beneficiaries to determine if the care provided was consistent with professionally recognized standards of health care, normally referred to as a Quality of Care Review. QIOs conduct these reviews to investigate complaints initiated by beneficiaries or the patients' representatives about the health care they received. In addition, Quality of Care Reviews may be performed as a result of other tasks that CMS assigns to the QIO.

Opportunity for Discussion

As part of the review process, we are required to give you an opportunity to discuss our initial findings before we make our final decision. Your response can be written or oral and must be received within 7 calendar days from the receipt of this letter in order for us to consider information you provide in our Final Determination. Please be advised that this is not an opportunity for you to submit additional medical information. If additional medical information is submitted, we will not consider it in rendering the Final Determination. However, we welcome

any policies, guidelines, rationale, and/or evidence-based information you would like us to consider in the review.

Summary of Findings

A QIO Peer Reviewer has reviewed the care provided to [Insert name of beneficiary who has consented here] by [name of practitioner] or at [name of provider]. Based on an evaluation of the information received, the following is the summary of our review.

Confirmed and/or identified concern(s):

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN LETTER

PREPARATION NOTE FOR QIO

The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- The standard of care associated with each concern,
- A statement of the analysis and findings for each concern, and
- A statement to the practitioner informing him/her that their consent is not required for the QIO to disclose specific findings about the review to the beneficiary.

This information should be consistent with the information contained in the QRD Form (See §5230.2)].

Please direct your response to:

[Insert QIO Name]
[Insert QIO Contact Person]
[Insert QIO Address]
[Insert QIO Contact Number]
[Insert QIO Fax Number]

If you have any questions about this letter or would like to make arrangements to discuss this case, contact the person listed above.

If the concerns involve both a physician/practitioner and a provider, the physician/practitioner and the representative for the provider may respond separately to the opportunity for discussion. However, we strongly encourage coordination of the responses.

If we do not receive your response within 7 calendar days from the receipt of this letter, the Initial Determination will become our Final Determination, and we will send you a letter noting this change. The information in this letter is confidential, and you may disclose it only in accordance with Federal regulations found in 42 CFR Part 480.

If you have any questions about this letter, please contact the above-named person within the time frame described above.

Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-4 – Final Initial Determination Letter to Practitioners/Providers with Request to Disclose (For Beneficiary Complaints)

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIO LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name (when the patient has consented to disclosure)
Medicare beneficiary identifier
Practitioner/Provider Name (If this applies)
Practitioner/Provider Number (If this applies)
Date of Admission/Service
Medical Record Number (if known)

Dear:

Previously, you were afforded the opportunity to discuss our review of care you provided in our letter (dated _____). This letter constitutes our Final Initial Determination based on a careful review of the information provided by the beneficiary in filing the complaint, information contained in the medical information, as well as any information provided during the opportunity for discussion.

Summary of Findings

The results of our review are as follows:

PREPARATION NOTE FOR QIO

The summary must include:

- the specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- the standard of care associated with each concern, and
- a statement of the analysis and findings regarding each concern, including specific information detailing the evaluation of information obtained as a result of the opportunity for discussion and any differences and/or changes between the Interim and Final Initial Determinations.

The information should be consistent with the information contained in the Quality Review Decision (QRD) Form.

Consent to Release Findings to the Beneficiary

We will inform beneficiaries about whether the care they were provided did or did not meet professionally recognized standards of care. In order for us to release to the beneficiary more specific facts about the actions of particular practitioners involved in the care of the beneficiary, and how their actions did or did not meet the standard of care, we must obtain consent from those practitioner(s) The findings we propose releasing to the beneficiary are attached to (or included in) this letter. If you are a practitioner, please review the language and indicate consent to our disclosing the information to the beneficiary within thirty calendar days from the date of this letter. Please note that we will treat your failure to indicate your consent as your declining to consent and the beneficiary will not be informed of these specific findings. In order to facilitate release of these specific findings to the beneficiary, please contact the QIO representative named below to discuss the attached findings:

Name of QIO Contact Person
Address
Telephone Number

PREPARATION NOTE FOR QIO:

- If the notice is addressed to the provider and/or physician practice or some other practitioner, insert the name of the practitioner(s) also notified and include the statement:
  - The following practitioner, [insert name(s)] also has been notified of our Final Initial Determination and contacted to obtain his/her consent to disclose the specific findings to the beneficiary.
- If the notice is addressed to a practitioner, insert the name of the provider if applicable. Do not specify other physicians or practitioners you may be notifying.
- If the notice is addressed to the provider and will also be sent to a physician practice or some other practitioner, insert into the provider's notice the name(s) of the practitioner(s) also notified and include the statement:
  - The following practitioner(s), [insert name(s)] also has been notified of our Final Initial Determination and contacted to obtain his/her consent to disclose the specific findings to the beneficiary.
- If the notice is addressed to a practitioner or physician practice, insert the name of the provider if applicable. Do not specify other physicians or practitioners you may be notifying.

Right to Request a Re-Review

PREPARATION NOTE FOR QIO

The QIO must select the appropriate paragraph depending on whether a **Retrospective** or **Concurrent** Review is being conducted (Do NOT include "For Retrospective Review" or "For Concurrent Review" heading in the actual letter). In addition, the references to the other practitioners receiving the letter should not be included if addressed to a practitioner.

For Retrospective Review

We are also notifying (name (See NOTES above)) of our Final Initial Determination. If you or (name (See NOTES above)) disagree with this Final Initial Determination, either party may request a Re-Review. To request a Re-Review, you must submit your request in writing within 15 calendar days from the date of this letter. Your request for a Re-

Review may include additional information and/or documentation, including medical information you believe supports your request for a Re-Review.
For Concurrent Review
We are also notifying (name (See NOTES above)) of our Final Initial Determination. If you or (name (See NOTES above)) disagree with this Final Initial Determination, you must submit your request in writing within 5 calendar days from the date of this letter. Your request for a Re-Review may include additional information and/or documentation, including medical information you believe supports your request for a Re-Review.

Your request for a Re-Review may be submitted via mail or facsimile to the following address:

QIO Name
Address
Facsimile Number

Please be advised that if a Re-Review is requested, you [practitioner] will again be provided the opportunity to consent to our disclosing information to the beneficiary after the Re-Review determination.

The information in this notice is confidential and may be re-disclosed only in accordance with federal regulations found in 42 CFR Part 480.

Sincerely,

Medical Director (or designated physician)
(Include title)

Appendix 5-4.1 – Beneficiary Quality of Care Complaint: Final Determination Letter to Practitioners and Providers

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIO LETTERHEAD

Date of Notice
QIO Liaison for Provider or Practitioner's Name
Name of Addressee
Address
City, State, and Zip Code

Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

Dear [insert name of Practitioner or Provider here]:

In our Initial Determination Letter, dated [insert date here], you were given the opportunity to discuss our review of the care you provided. This letter constitutes our Final Determination based on a review of the complaint, the medical information, and any correspondence provided during the opportunity for discussion.

Summary of Review

A QIO Peer Reviewer has reviewed the care provided to [Insert name of beneficiary relevant to the complaint] by [name of practitioner] or at [name of provider]. Based on an evaluation of the information received, the following is the summary of our review.

Confirmed and/or identified concern(s) [should be the same as in the Interim Determination Letter]

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER

PREPARATION NOTE FOR THE QIO
The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),

- The standard of care associated with each concern,

- A statement of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information and, if held, information obtained as a result of the opportunity for discussion with the involved practitioner or provider, and

- For each concern, there should be a statement about whether or not the care provided was consistent with standards of health care.

This information should be consistent with the information contained in the QRD Form (See §5230.2)]

If [Insert QIO name here] identifies quality of care concerns that represent a significant departure from the expected standard of health care and/or identifies patterns of care that may have significance beyond a single episode, a determination may be made that further intervention activities are required. If this occurs, you will be notified in writing and given the opportunity to discuss the concern(s) with [Insert QIO name here].

Non-confirmed concern(s):

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER.

PREPARATION NOTE FOR QIO
The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the initial intake (See §5110.1).

- The standard of care associated with each concern and a statement of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information and, if held, information obtained as a result of the opportunity for discussion with the involved practitioner or provider.

This information should be consistent with the information contained in the QRD Form (See §5230.2)]

This information will be entered into [the CMS database]. On an ongoing basis, we analyze patterns of care involving quality concerns that may have significance beyond a single episode. The QIO provides this information to CMS as requested.

Please be advised that the Medicare Beneficiary has the right to request Reconsideration. If a request is received, this determination may or may not change as a result of the QIO reviewing this case again during the Reconsideration process. In the event that the Reconsideration does result in a change in the Final Determination, you will be notified in writing.]

Right to Request Reconsideration

If you disagree with this Final Determination, you may also request Reconsideration by submitting your request within 3 calendar days from the receipt of this letter. Your request for Reconsideration may include additional information and/or documentation, including

Your request for Reconsideration can be either written or oral using the contact information below:

[Insert QIO Name]
[Insert QIO Contact Person]
[Insert QIO Address]
[Insert QIO Contact Number]
[Insert QIO Fax Number]

Please be advised that if Reconsideration is requested, this determination may or may not change as a result of the QIO reviewing this case again during the Reconsideration process. In the event that the Reconsideration does result in a change in the Final Determination, you will be notified in writing.

The information in this notice is confidential and may be disclosed only in accordance with Federal regulations found in 42 CFR Part 480.
Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-4.2 – Beneficiary Quality of Care Complaint: Final Determination Letter to Beneficiary/ Beneficiary Representative

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIO LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

Dear [insert name of Beneficiary or Representative]

Thank you for your patience while we completed a full and comprehensive review of the quality of care concerns you raised [(If available, include copy of the quality of care concern form signed by the complainant]). Our Final Determination is based on a physician's careful review of:

- Information you provided in filing the complaint
- Medical information
- Any information provided during the practitioner/provider's opportunity for discussion.

Summary of Review

The following is the summary of our review.

Confirmed and/or identified concern(s):

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER.

PREPARATION NOTE FOR THE QIO
The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the initial review (See §5110.1),
- The standard of care associated with each concern, and
- A summary of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information and, if held, information obtained as a result of the opportunity for discussion with the involved practitioner or provider.

The information should be consistent with the information contained in the QRD Form (See §5230.2)]

Non-confirmed concern(s):
NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN LETTER

PREPARATION NOTE FOR THE QIO
The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- The standard of care associated with each concern, and
- A summary of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information, and including any information obtained as a result of the opportunity for discussion with the involved practitioner or provider.

The information should be consistent with the information contained in the QRD Form (See §5230.2].

Your Right to Request a Reconsideration

If you disagree with this determination, you may request Reconsideration by submitting your request within three (3) calendar days from the receipt of this letter. You may provide additional information and/or documentation, including medical information that will help with your request.

Your request for Reconsideration can be either written or oral using the contact information below:

[Insert QIO Name]
[Insert QIO Contact Person]
[Insert QIO Address]
[Insert QIO Contact Number]
[Insert QIO Fax Number]

NOTE: The determination in this letter may or may not change as a result of us reviewing this case again during the Reconsideration process. If it does, you will be notified in writing.

The information in this notice is confidential and may be disclosed only in accordance with Federal regulations found in 42 CFR Part 480.

Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-5 – Re-Review Determination Letter to Providers/Practitioners with Request to Disclose (For Beneficiary Complaints)

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIO LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name (when the patient has consented to disclosure)
Medicare beneficiary identifier
Practitioner/Provider Name (if this applies)
Practitioner/Provider Number (if this applies)
Date of Admission/Service
Medical Record Number (if known)

Dear:

Previously, you received our Final Initial Determination letter, dated _________, about care you provided [to the beneficiary listed above. (Only include where the beneficiary has consented to the disclosure of his or her name.)] We received your request for a Re-Review, and have completed the Re-review. This letter conveys the final results of our Re-Review and constitutes our FINAL decision on this matter. The Re-review was completed by a Peer Reviewer who was not involved in the original Determination.

Summary of Re-Review Findings

Based on a thorough review of all information, the Re-Review Peer Reviewer has determined

PREPARATION NOTE FOR QIO

The summary must include:

- the specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- the standard of care associated with each concern, and
- a statement of the analysis and findings regarding each concern, including the analysis of any additional information submitted as part of the Re-Review request and/or changes between the Initial Determination and Re-Review.

This information should be consistent with the information contained in the Quality Review Decision (QRD) Form.

Consent to Release Findings to the Beneficiary

We will inform beneficiaries about whether the care they were provided did or did not meet professionally recognized standards of care. In order for us to release more specific findings to the beneficiary, we must obtain consent from practitioner(s) involved in the care of the patient. The findings we propose releasing to the beneficiary are attached to (or included in) this letter. If you are a practitioner, please review the language and indicate consent to our disclosing the information within thirty calendar days from the date of this letter. Please note that we will treat your failure to indicate your consent as your declining to consent, and the beneficiary will not be informed of these specific findings. In order to facilitate release of these specific findings to the beneficiary, please contact the QIO representative named below to discuss the attached findings:

Name of QIO Contact Person
Address
Telephone Number

PREPARATION NOTE FOR QIO:

- If the notice is addressed to the provider or practitioner group, insert the name of the practitioner(s) also notified and the following language.
  - The following practitioner, [insert name(s)] also has been notified of our Re-Review decision and contacted to obtain his/her consent to disclose the specific findings to the beneficiary.
- If the notice is addressed to the practitioner, insert the name of the provider if applicable. Do not specify other practitioners you may be notifying.
- If the notice is addressed to the provider and will also be sent to a physician practice or some other practitioner, insert into the provider's notice the name(s) of the practitioner(s) also notified and include the statement:
  - The following practitioner(s), [insert name(s)] also has been notified of our Final Initial Determination and contacted to obtain his/her consent to disclose the specific findings to the beneficiary.
- If the notice is addressed to a practitioner or physician practice, insert the name of the provider if applicable. Do not specify other physicians or practitioners you may be notifying.

Again, this constitutes the QIO's FINAL decision on this matter, and no further appeal rights are available. The information in this notice is confidential and may be re-disclosed only in accordance with Federal regulations found in 42 CFR Part 480.

Sincerely,

Medical Director (or designated physician)
(Include title)

Appendix 5-5.1 – Beneficiary Quality of Care Complaint: Reconsideration Determination Letter to Practitioners and Providers

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIO LETTERHEAD

FINAL NOTIFICATION

Date of Notice
QIO Liaison for Provider's or Practitioner's Name
Name of Addressee
Address
City, State, and Zip Code

Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

[NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER.

- If the notice is addressed to the provider or practitioner group, insert the name of the practitioner(s) also notified.

- If the notice is addressed to the practitioner, insert the name of the provider if applicable. Do not specify other practitioners you may be notifying.

- If the notice is addressed to the provider and will also be sent to a physician practice or some other practitioner, insert into the provider's notice the name(s) of the practitioner(s) also notified.

- If the notice is addressed to a practitioner or physician practice, insert the name of the provider if applicable. Do not specify other physicians or practitioners you may be notifying.]

Dear [Insert name of Practitioner or Provider here]:

You previously received our letter, dated [insert date here], about care you provided to [insert beneficiary name here]. We received your request for Reconsideration and have completed the Peer Review. Following CMS policy, a Peer Reviewer who was not involved in the prior

determination of the initial review completed the Reconsideration review. This letter conveys the results of your Reconsideration review and constitutes our final decision on this matter.

Summary of Reconsideration Review

Based on a review of the information received, the following is the summary of our Reconsideration review.

Confirmed and/or identified concern(s) [should be the same as Final Determination letter]: [NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER.

PREPARATION NOTE FOR THE QIO
The summary of confirmed concerns must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- The standard of care associated with each concern, and
- A summary of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information and, if held, information obtained as a result of the opportunity for discussion with the involved practitioner or provider.

The information should be consistent with the information contained in the QRD Form (See §5230.2].

Non-confirmed concern(s): NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN LETTER

PREPARATION NOTE FOR THE QIO
The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- The standard of care associated with each concern, and
- A summary of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information and, if held, information obtained as a result of the opportunity for discussion with the involved practitioner or provider.

The information should be consistent with the information contained in the QRD Form (See §5230.2)]

This information will be entered into [the CMS database]. On an ongoing basis, we analyze patterns of care involving quality concerns that may have significance beyond a single episode. The QIO provides this information to CMS upon request.

Again, this constitutes the QIO's final decision on this matter, and no further appeal rights are available. The beneficiary or patient representative will be notified of the results of the QIO Quality of Care Review. The information in this notice is confidential and may be disclosed only in accordance with Federal regulations found in 42 CFR Part 480.

Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-5.2 – Beneficiary Quality of Care Complaint: Reconsideration Determination Letter to Beneficiary/Beneficiary Representative

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

NOTE: This letter template applies to beneficiary complaints received after July 31, 2014.

QIO LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

Dear [insert name of Beneficiary or Representative here]

We received your request for a different reviewer to look at your quality of care concerns under the Reconsideration process. The Reconsideration review findings are below, and this is our final determination about the quality of the medical care you received.

Summary of Review

The following is the summary of our Reconsideration Peer Review.

Confirmed and/or identified concern(s) [should be the same as Final Determination letter]:

[NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER.

PREPARATION NOTE FOR THE QIO
The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- The standard of care associated with each concern, and

- A summary of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information and, if held, information obtained as a result of the opportunity for discussion with the involved practitioner or provider.

The information should be consistent with the information contained in the QRD Form (See §5230.2)]

Non-confirmed concerns:
NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN LETTER

PREPARATION NOTE FOR THE QIO
The summary must include:

- The specific concerns identified by the beneficiary and any concerns identified by the QIO based on the Scope of Review (See §5110.1),
- The standard of care associated with each concern, and
- A summary of the analysis and facts the QIO determines are pertinent to its findings, including references to medical information and, if held, information obtained as a result of the opportunity for discussion with the involved practitioner or provider.

The information should be consistent with the information contained in the QRD Form (See §5230.2)]

This information will be entered into [the Centers for Medicare & Medicaid Services (CMS) database]. On an ongoing basis, we review quality of care services and concerns that may identify patterns of care that may have significance beyond a single episode. The QIO provides this information to CMS as requested to improve the overall quality of care for all Medicare beneficiaries.

Again, this is the final decision on this matter, and no further appeal rights are available. In addition, the information in this notice is confidential and may be disclosed only in accordance with Federal regulations found in 42 CFR Part 480.

Thank you for sharing your concerns with us. If you have any questions, please do not hesitate to contact us:

[Insert QIO Name]
[Insert QIO Contact Person]
[Insert QIO Address]
[Insert QIO Contact Number]
[Insert QIO Fax Number]

Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-6 – General Quality of Care Reviews - Initial Determination Letter with Right to Request Reconsideration to Practitioners and Providers

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIO LETTERHEAD

INITIAL NOTIFICATION

Date of Notice
QIO Liaison for Provider or Practitioner's Name

Name of Addressee
Address
City, State, and Zip Code

Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

Dear [Insert name of Practitioner or Provider here]:

You are receiving this notification because [Insert QIO name here] identified a potential quality of care concern about care you provided to [Insert beneficiary name here].

[Insert QIO name here] is the Quality Improvement Organization (QIO) authorized by the Centers for Medicare & Medicaid Services (CMS) to review Medicare cases in [Insert QIO area/region here] to determine if the health care services provided to Medicare beneficiaries meet professionally recognized standards of care, are medically necessary, and are delivered in the most appropriate setting. Our primary purpose is to identify areas where health care services can be improved and provide feedback to facilities and practitioners. This Peer Review is intended to be a collegial interaction with the goal of improving patient care.

We have completed our review of the episode of care referenced above. A [Insert QIO name here] Peer Reviewer has carefully reviewed the medical information.

Summary of Review

Based on a review of the information received, the following is the summary of our review.

Confirmed and/or identified concern(s):

[NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER

PREPARATION NOTE FOR THE QIO:
The review findings must include:

- A statement for each quality of care concern that care did or did not meet the standard(s) of care,
- The standard(s) identified by the QIO for each quality of care concerns, and
- A specific statement conveying facts describing how the practitioner and/or provider did or did not meet specific criteria within the standard.

Non-confirmed concern(s):

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN LETTER

PREPARATION NOTE FOR QIO:
The review findings must include:

- A statement for each of the quality of care concerns that care did or did not meet the standard(s) of care,
- The standard(s) identified by the QIO for each quality of care concerns, and
- A statement for each quality of care concern that care did or did not meet the standard(s) of care.

If you disagree with this quality of care concern(s) determination, you may request Reconsideration. Your request should include the reason for your dissatisfaction with our determination and any additional information you may wish to submit. Your request for Reconsideration can be written or oral and must be submitted within three (3) calendar days from receipt of this letter using the following contact information:

[Insert QIO Name]
[Insert QIO Contact Person]
[Insert QIO Address]
[Insert QIO Contact Number]
[Insert QIO Fax Number]

NOTE: If a request for Reconsideration is not submitted within the appropriate timeframe, this notification will be considered our Final Determination.

This information will be entered into [the Centers for Medicare & Medicaid Services (CMS) database]. On an ongoing basis, we analyze patterns of care involving quality concerns that may have significance beyond a single episode. The QIO provides this information to CMS as requested to improve the overall quality of care for all Medicare beneficiaries.

The information in this notice is confidential and may be disclosed only in accordance with Federal regulations found in 42 CFR Part 480. Thank you for your participation in the improvement of the Medicare program.

Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-7 – General Quality of Care Reviews: Final Reconsideration Determination Letter to Practitioners and Providers

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

NOTE: Use this letter template if a request for reconsideration is submitted within the appropriate timeframe.
QIO LETTERHEAD

FINAL NOTIFICATION

Date of Notice
QIO Liaison for Provider or Practitioner's Name

Name of Addressee
Address
City, State, and Zip Code
Beneficiary Name
Medicare *beneficiary identifier*
Practitioner/Provider Name
Practitioner/Provider Number (CCN/NPI/UPN)
Date(s) of Service

Dear [insert name of Practitioner or Provider here]:

You previously received our Initial Determination letter, dated [Insert date here], about the care you provided to [Insert beneficiary name here]. We received your request for Reconsideration, and have completed the Reconsideration Peer Review. A [Insert QIO name here] Peer Reviewer has carefully reviewed the medical information, and any additional information that was provided. This Peer Reviewer was not the same Peer Reviewer who initially reviewed this matter. This letter conveys the results of your Reconsideration and constitutes our final decision on this matter.

Summary of Review

Based on a review of the information received, the following is the summary of our review.

Confirmed and/or identified concern(s):

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN THE LETTER

PREPARATION NOTE FOR THE QIO:
The review findings must include:

- A statement for each quality of care concern that care did or did not meet the standard(s) of care,
- The standard(s) identified by the QIO for each quality of care concern, and
- A specific summary conveying facts describing how the practitioner and/or provider did or did not meet specific criteria within the standard.

Non-confirmed concern(s):

NOTE: The following is for instructional purposes ONLY. DO NOT INCLUDE IN LETTER

PREPARATION NOTE FOR QIO:
The review findings must include:

- A statement for each quality of care concern that care did or did not meet the standard(s) of care,
- The standard(s) identified by the QIO for each quality of care concern, and
- A specific summary conveying facts describing how the practitioner and/or provider did or did not meet specific criteria within the standard.]

This information will be entered into [the Centers for Medicare & Medicaid Services (CMS) database]. On an ongoing basis, we analyze patterns of care involving quality concerns that may have significance beyond a single episode. The QIO provides this information to CMS as requested.

The information in this notice is confidential and may be disclosed only in accordance with Federal regulations found in 42 CFR Part 480. Thank you for your participation in the improvement of the Medicare program.

Sincerely,

Medical Director (or designated physician)
[Insert title here]

Appendix 5-8 – REQUEST FOR QIO REVIEW FORM

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

TO: QIO Name
Address
City, State, Zip

I. Requesting Agency/Organization and Contact Person

Agency/Organization: ______________________________Phone #: ________________

Contact Person: _____________________________ Email: ____________

II. Patient Information

Patient Name: __________________ *Medicare beneficiary identifier*: ________________

Date of Birth: __________________ Sex: Male______ Female______

Facility Name:________________________

Provider Name: _______________________ Provider Phone #: _______________

Admit Date: __________________________ Discharge Date: ________________

III. Referral

Type of Referral (check one): Quality of Care: ________________ Other: ___________

Reason for Review Request or Quality of Care Concern Identified (be specific): (Quality of Care e.g., over-prescribing drugs or prescribing the wrong drug, failing to diagnose a medical problem that is found later, misreading x-rays to identify a medical problem, failing to get back to a patient with medical results in a timely manner, failing to provide appropriate care after a surgical procedure)___

____
____
____
____
____
____

________________________ __________________
Reviewer's Signature Date

Do you need an update on case upon completion of QIO's review? (Check one):
Yes ________ No _________

THIS SECTION FOR QIO USE ONLY

Was a review conducted? Yes__________ No__________

Review Results: ____

____

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____

____

Additional Information: ____

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7115 - Content of Denial Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. Format of Notice

Make your denial notices understandable and write the notices in "plain English." In addition, make sure that the beneficiary notice:

- Is in letter format;
- Is addressed to the beneficiary or his/her representative, if applicable (Where the beneficiary is deceased, address the notice to the beneficiary's representative or estate);
- Has a personalized salutation line (e.g., "Dear Mr. Smith" instead of "Dear beneficiary" or "Dear representative"); and
- Includes all pertinent information in the body of the notice (i.e., attachments or enclosures are not acceptable if they are in lieu of required information).

B. Identifying Information

The heading of the notice must include:

- The date of notice;
- The beneficiary's name;
- The beneficiary's Medicare *beneficiary identifier*;
- The beneficiary's address, his/her representative's address, or address of the person handling the beneficiary's estate if beneficiary is deceased;
- The provider's name;
- The provider's Medicare number (not necessary if you transfer notices to the A/B MAC (A) electronically);
- The medical record number (if known);

- The admission date (for denials related to "deemed" admission date cases, use the actual admission date); and

- The attending physician's name (for the services in question).

C. Specificity of Notice

The body of the notice must include:

- Identification of QIO -- Include a brief statement concerning your duties and functions under the Act.

- Reason for Admission -- Specify the reason for the admission. For partial denials (i.e., part of the stay is covered), include a statement specifying that the admission was medically necessary and appropriate (Do not include this statement in "deemed" admission date denial notices).

- Opportunity for Discussion -- Reference your discussions with the attending physician and provider. This requirement is met if your notice states that the involved physician and hospital were provided with an opportunity to discuss the case.

This applies to initial denial determinations and DRG assignment changes. When the DRG assignment is changed (either higher or lower), provide the hospital and physician an opportunity to discuss the DRG change.

- Solicitation of Views -- Reference your solicitation of the beneficiary's or his/her representative's views. Include the date of your discussion (This provision applies only when your review is based on a beneficiary's, his/her representative's, or provider's request for review of a continued-stay HINN).

- Reason for Denial -- Include the relevant facts explaining the reason(s) for the denial determination. The discussion in the beneficiary notice should be in layman's terms, and include all the information necessary to support the denial determination. The discussion must be specific to the individual case (i.e., it is unacceptable to state only that the services were medically unnecessary, inappropriate, or constituted custodial care).

    - For procedure denials, specify either that the patient requires the procedure but the services could be performed on an outpatient basis or that the patient did not require the surgery and, therefore, the procedure was not medically necessary (See Exhibit 7-28).

    - For deemed admission denials, continued-stay denials, day outlier denials, and partial admission denials (for non-PPS providers), specify the date(s)/period(s) for the stay or services that are not approved as being medically necessary or appropriate (A partial denial includes services/items that Medicare determined to be covered). In addition, for day outlier and partial admission denials (non-PPS

providers), specify the total number of denied days (See Exhibits 7-26, 7-27, and 7-29).

- For continued-stay denials (related to HINNs) involving "deemed" admission situations, modify the notice to include the applicable language (e.g., reason for denial, periods approved and denied, liability determination) (See Exhibits 7-26 and 7-27).

- For cost outlier denials, specify the dates, charges, and specific services/items that will not be approved as being medically necessary or appropriate (See Exhibit 7-30).

- For day outlier denials, distinguish between those days that were not medically necessary and those where the beneficiary could have safely and effectively received the services on an outpatient basis.

- For changes to DRG coding information that affect the DRG assignment (either higher or lower), include a listing of the diagnosis and procedure codes and a narrative description as submitted by the provider and as changed by you along with the reason for the changes. Be as specific as possible in explaining the reason(s) for the changes (See Exhibit 7-31). Do not notify the hospital of changes to DRG coding information when the changes do not revise the DRG assignment.

- For billing errors, explain that the error precludes you from completing review of the case. Instruct the provider to submit an adjusted claim to the A/B MAC (A) (in accordance with your agreements with the A/B MAC (A) and provider) (See Exhibit 7-24).

- For circumvention of PPS denials, specify that you are denying the second admission. Explain whether the denial is based on services that should have been furnished during the first admission, on an inappropriate transfer from a PPS unit to a PPS-excluded unit, or on an inappropriate transfer from a PPS-excluded unit to a PPS unit. Cite the provision of the law that authorizes QIOs to deny payment for circumvention of PPS (See Exhibit 7-34).

- Liability Determination for the Beneficiary and Provider -- Include a statement of the beneficiary's or his/her representative's and the provider's liability determinations (under §1879 of the Act), including a detailed rationale for the decision (This applies only to initial medical necessity/custodial care denial determinations) (See Exhibit 7-20).

    - For denials based on circumvention of PPS, explain that the limitation on liability provisions under §1879 do not apply, that the hospital is liable for the denied charges, and that the beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare (See Exhibit 7-34).

- If the beneficiary or his/her representative is found liable, specify the date of the prior notice. Include a copy of the notice. Do not include a copy of the beneficiary's prior notice with the provider/physician notice unless the notice was issued by that provider.

- If the provider is found liable, specify the dates of liability (if applicable) and the source: brochures, prior notices (including dates), manual references, criteria, etc. Reference must be specific to individual case. Give the provider a copy of the source material referenced by you (See Exhibit 7-20, Conditions II, III, V, IX and X).

- For denials based on a beneficiary's or his/her representative's request for review of a continued-stay HINN or a provider's request for review of a proposed continued-stay HINN, include the date of your phone notification to the beneficiary or his/her representative (See Exhibit 7-20, Conditions VI and VII).

- For denials involving review of a HINN, do not approve payment for additional days under §1879 of the Act for purposes of post-discharge planning (i.e., grace days). A provider who issued a HINN has demonstrated knowledge that Medicare will not cover the services and, therefore, §1154(a)(2)(b) is not applicable (See Exhibit 7-20, Conditions VI and VII).

- For denials based on concurrent review not involving a HINN, you may approve payment for up to two additional days under §1879 of the Act for purposes of post-discharge planning (i.e., grace days) (See Exhibit 7-20, Condition VIII).

NOTE: When you deny a case that involves non-covered services such as routine foot or dental care, do not apply the provisions of §1879.

- Liability Determination for the Physician -- Include a statement of the payment liability determination related to denied physician services (Under §§1842(l) and 1879 of the Act). Include a detailed rationale for the decision (Applies to hospital inpatient and ambulatory/outpatient surgical procedures/services and cost outlier(s) with physician component denials that are determined to be medically unnecessary).

  - For denials involving claims for services billed on an assigned basis (whether furnished by Medicare participating or nonparticipating physicians), make your liability determination in accordance with the provisions of §1879 of the Act.

  - For denials involving services billed on an unassigned basis (by nonparticipating physicians), make your liability determination in accordance with the provisions of §1842(l) of the Act.

NOTE: The determination as to whether the physician is protected from payment liability (when the physician accepts assignment) under §1879 of the Act or from making a refund to the

beneficiary or his/her representative (when the physician does not accept assignment) under §1842(l) of the Act is made when the initial denial decision is furnished. In both situations make a determination of the physician's and the beneficiary's knowledge of the non-covered services. Unless there is evidence to the contrary (e.g., the physician annotated in the medical record that he/she has given the beneficiary a written advance notice), presume that the beneficiary or his/her representative had no knowledge that Medicare would not pay for the denied items or services furnished by the physician. On a case-by-case basis, the physician may challenge this presumption when you offer the physician an opportunity to discuss the case. At the same time, ask the physician if he/she accepted assignment (if you were unable to determine this information from your review of the documents in the medical record). The physician should be able to provide you with the information you need as well as a copy of the written advance notice that he/she gave the beneficiary or his/her representative.

- Beneficiary Indemnification for Provider Services -- Include a statement related to the indemnification of the beneficiary or his/her representative when the provider has been found liable for the denied services.

  Include the name, address, and telephone number of the A/B MAC (A, B, or HHH) where the beneficiary or his/her representative can file a request for indemnification.

  Inform the beneficiary that the following documents must be provided to the A/B MAC (A, B, or HHH):

  - A copy of the denial notice;

  - A copy of the bill for the services; and

  - A copy of the payment receipt from the provider or any other evidence showing that the beneficiary paid the provider.

  Instruct the beneficiary that the request must be filed within 6 months of the date of your denial notice (See 42 CFR 411.402(a)(4)).

  Specify that if the beneficiary or his/her representative and the provider are not held liable §§1879(a)(1) and (2) conditions are met, he/she is responsible only for payment of any deductible, coinsurance, and convenience services and items normally not covered by Medicare that are furnished during the admission (See Exhibit 7-20, Condition I).

  In addition, specify that if the beneficiary or his/her representative is not held liable but the provider is held liable, he/she is responsible only for payment of any convenience services and items normally not covered by Medicare for the denied period. In this situation, the beneficiary or his/her representative is not responsible for the denied services including any applicable deductible and coinsurance (See Exhibit 7-20, Condition II).

- Beneficiary Indemnification for Physician Services -- Include a statement related to the indemnification of the beneficiary or his/her representative for denied physician's services (e.g., inpatient procedure, cost outlier with a physician component, and ambulatory/outpatient surgical denials).

  Include the name, address, and telephone number of the A/B MAC (B) where the beneficiary or his/her representative can file a request for indemnification.

  Inform the beneficiary that the following documents must be provided to the A/B MAC (B):

  - A copy of the denial notice;

  - A copy of the bill for the services; and

  - A copy of the payment receipt from the physician or any other evidence showing the beneficiary paid the physician.

  Instruct the beneficiary that the request must be filed within 6 months of the date of your denial notice (See 42 CFR 411.402(a)(4)).

  For denials involving services billed on an assigned basis by a Medicare participating or nonparticipating physician, specify that the beneficiary or his/her representative should contact the A/B MAC (B) for any refund (See Exhibit 7-20, Conditions III, XI, and XII).

  For denials involving services billed on an unassigned basis by a nonparticipating physician, specify that the beneficiary or his/her representative should contact the physician for any refund (See Exhibit 7-20, Condition IIIA).

- Beneficiary's Future Payment Liability -- Include a statement related to the liability for payment of denied services occurring in the future that involve the same, or reasonably comparable, conditions.

  This applies only to initial medical necessity/custodial (level of) care denial determinations.

  Do not include such a statement if the denial is for a procedure that cannot be repeated (e.g., total removal of an organ).

- Reconsideration Rights -- Include a statement of the reconsideration rights (including expedited reconsideration, if applicable) of the beneficiary or his/her representative, provider, and attending physician (See Exhibit 7-21). This applies only to initial denial determinations.

  The statement must specify:

  - The places that the beneficiary or his/her representative may file a reconsideration (i.e., Social Security Administration (SSA) Office, Railroad Retirement Office, if applicable, or at your office);

  - The time requirements to file a request; and

  - The possible outcomes of your review as a result of a request for reconsideration.

- Beneficiary Right To Legal Representation -- Include a statement informing the beneficiary or his/her representative of the options for obtaining attorney representation at any step of the appeal process, of the availability of free legal services organizations, and to contact the local social security office for additional information, if needed (See §206(c) of the Act). This requirement is applicable to QIOs involved in the Medicare program by 42 USC 1395(ii). This applies only to initial medical necessity/custodial (level of) care denial determinations.

  Insert the following statement, which shall not be altered, after the reconsideration rights paragraph in all initial denials where the beneficiary or his/her representative receives your notification:

  - "If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify."

- Beneficiary Right to Review the Medical Record -- Include a statement informing the beneficiary or his/her representative of the right to examine his/her complete medical record and to receive a copy of that record. This applies only to initial medical necessity/custodial (level of) care denial determinations.

  Insert the following statement, which cannot be altered, after the beneficiary right to legal representation paragraph in all initial denials where the beneficiary or his/her representative receives your notification:

  - "You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information."

  If the beneficiary or his/her representative requests the record, redact any QIO deliberations and the names of any QIO review coordinators, physician advisors, or

consultants from the material before its release. All practitioner-specific information must be released. Disclose the names of all practitioners who were involved in the patient's treatment and whose names appear in the medical record or other pertinent information.

NOTE: Do not make notations on pages of the medical record in order to minimize the amount of redacting required.

Provide the record at a reasonable cost. The cost is limited to the cost of copying, redacting, and mailing the information.

- Re-review Rights Related to DRG Assignment Changes -- Include a statement of the re-review or reopening rights of the provider and physician. Re-review or reopening rights do not apply when the DRG assignment does not change.

  Specify the place to file a review (i.e., QIO).

  Specify the time requirements for filing such a request.

NOTE: The re-review or reopening rights do not apply to coding changes that do not affect DRG assignment.

- Signature -- For denial notices include the signature, including title, of the QIO Medical Director or the signature of the QIO physician to whom the Medical Director has delegated this authority. If you delegate this authority to your physician reviewers, do so in accordance with the confidentiality regulations, which specify that the identity of the reviewer cannot be disclosed unless the individual gives his/her consent (See 42 CFR 476.101(b) and 133(a)(2)(iii)). The Billing Error Denial Notice (Exhibit 7-24) may also be signed by the QIO Chief Executive Officer (CEO) or appropriate designee. DRG assignment changes that do not involve medical judgment may also be signed by the Accredited Record Technician or Registered Record Administrator.

7220 - Basic Elements for Quality Concern Notices

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Your quality concern notices must be clear, informative, and non-threatening (e.g., do not quote at length from QIO regulations). In addition, all notices must contain the following basic elements:

A. Heading

The heading of the notice must include:

- Your letterhead;
- The date of the notice;
- The name and address of the addressee; and
- Case-identifying information. Specify the patient's name, patient's *Medicare beneficiary identifier*, provider name, provider number, date of admission/service, and medical record number (if known).

B. Body

The body of the notice must contain:

- A salutation;
- A brief statement concerning your duties and functions under the Act;
- A brief statement explaining the purpose of your quality review activities and acknowledging the importance of the provider's/physician's cooperation;
- A brief summary of the background of the case. Specify the name of the patient, the name of the provider, the procedure, treatment, condition, and/or services involved, as appropriate; and
- A confidentiality and re-disclosure statement.

C. Signature

The notice must be signed by the medical director or the QIO physician to whom the medical director has delegated this authority. Include a title with the signature.

7430 - Reconsideration Process

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

A. Provision of Information to Parties

Prior to the reconsideration, give all parties, upon request, an opportunity to examine or obtain a copy of all the material upon which the initial denial determination was based, including the complete medical record and summary of your findings and conclusions in making the initial denial determination. Inform the requester that he may have to pay a reasonable fee for the redaction of, reproduction of, and postage for, the material requested (If patient information would be harmful to the beneficiary, provide it to the beneficiary's designated representative upon receiving the request in writing pursuant to 42 CFR 480.132(c)).

In accordance with regulations governing disclosure of confidential QIO information and regulations at 42 CFR 478.24(a), do not give a party access to:

- Your deliberations; and

- The identity of your review coordinators, physician advisors, or consultants that assisted in reviewing the case (unless they have consented to release of their names).

Establish and implement procedures to segregate your deliberations and identifiers from the medical records when redacting.

No document or other information produced by you in connection with your deliberations in making reconsiderations under Title XI of the Act shall be subject to subpoena or discovery in any administrative or civil proceeding, except that you shall provide, upon request of a practitioner or other person adversely affected by such a determination, a summary of the organization's findings and conclusions in making the determination (See §1160(d) of the Act).

B. Provision For Submittal of Additional Information from Parties

Give all parties the opportunity to present additional documentary materials (e.g., new evidence) for consideration.

C. The Reconsideration Proceedings

Conduct the reconsideration proceedings as spelled out in your contract with CMS. Conduct a medical records review at your office with no party being present, or conduct proceedings similar to an evidentiary hearing. In either case, give the party advance notice of the date of the reconsideration to allow sufficient time for submission of evidence. Reschedule a reconsideration if a party submits a written request presenting reasonable justification for rescheduling.

If your contract calls for an evidentiary hearing:

- Give any party the opportunity to ask reasonable questions (e.g., to clarify information presented) of you or of any person who gives testimony; and

- Do not deny any involved party access to the hearing either while you present information or while another party (or a witness) presents information.

You are not required to have your legal counsel attend even if legal counsel for a party attends. In addition, you are not required to make a transcript of the reconsideration proceedings. A summary of the proceedings is adequate.

D. Evidence at Reconsideration

Consider all information in the medical record, the basis for the initial determination, and any additional evidence submitted by a party.

E. Areas of Consideration

Make a determination on medical necessity, reasonableness and appropriateness of setting, and whether the beneficiary/physician/provider knew or should have known that the care in question was not covered.

F. Timing of the Reconsidered Determination

Complete your reconsidered determination and send written notice within the timeframes that follow:

- For preadmission or pre-procedure or assistant at cataract surgery reviews, within 3 working days after you receive the reconsideration request. Apply this timeframe if the initial denial determination was made before the beneficiary was admitted to the institution or before surgery was performed and a timely expedited reconsideration request was made (see §7410.B.2).

- When the beneficiary is a hospital inpatient, within 3 working days after you receive the reconsideration request. Apply this timeframe if the initial denial determination was made while the beneficiary was still in the hospital and a timely expedited reconsideration request was made (See §7410.B.3).

- When the beneficiary is an inpatient in a SNF or receiving home health agency (HHA) services, within 10 working days after you receive the reconsideration request. Apply this timeframe if the beneficiary is still an inpatient in a SNF for the stay in question or is receiving home health services for the stay in question when you receive the request.

- When the beneficiary is receiving non-institutional services, is no longer an inpatient, or does not file a timely expedited request, within 30 working days after you receive the reconsideration request. Apply this timeframe if the initial denial determination concerns ambulatory or non-institutional services (except pre-procedure reviews), the beneficiary is no longer an inpatient in a hospital or SNF and is not receiving home health services for the stay in question, or the party does not file a timely request for expedited reconsideration (see §§7410.B.1 and 2).

Maintain a system, such as a log, for documenting your receipt of the request for reconsideration. Receipt, unless otherwise proven, means the day that you have in your records documentation that a notice was received. A party may request additional information to further explain the determination within 30 working days, and may request a reconsideration within 60 days of receiving the explanation (or within 30 days for an Appeals Council hearing).

G. Notices of a Reconsideration Determination

Notices to Parties -- Notify all parties in writing of your reconsidered determination. Discuss in detail the reasons for the initial and reconsidered determinations. Ensure that the appellant understands the reason(s) for your determination and provide support for your determination should the case be heard by an ALJ.

NOTE: Do not send beneficiaries or physicians reconsideration notices for circumvention of PPS (See §7440 for further instructions for processing circumvention of PPS reconsiderations).

All reconsideration notices must contain the following elements unless otherwise specified (see Exhibits 7-40 through 7-50):

- A brief statement concerning your duties and functions under the Act (Cite the regulatory basis for your review authority);

- The date that the reconsideration was requested and the party who requested it;

- The date of the admission or procedure, the name of the provider, and the reason for the admission or the name of the procedure furnished;

- A detailed explanation of the reason for the initial denial determination. A statement that the care was not medically necessary is not an adequate explanation (see §7115.C.5);

- The qualifications of the physician(s) who reviewed the case at the reconsideration level in a manner consistent with your disclosure requirements;

- A brief statement explaining that the provider and practitioner were given an opportunity to provide additional information;

- A clear explanation of the reasons for the reconsidered determination, including a narrative description of the medical facts and a detailed rationale for the determination. Provide the appropriate statutory and regulatory citations. Include an evaluation of any new points raised as part of the reconsideration request. If no new points are raised, state this in your notice;

- A statement about each party's liability for payment. State the initial liability determination for each party, including the rationale for each liability determination. State the reconsidered determination for each party. Provide a clear discussion of the

Medicare payment consequences of the reconsidered determination for the beneficiary, provider, and/or physician, including the rationale for the liability determination;

- Fully document your determination that the beneficiary/provider/practitioner knew or should have known that the care in question was not covered. The following are examples of rationales that would support your liability determination (see 42 CFR 411.406, §§7115.C.6 and 7):

    - The beneficiary received written notice from you, the fiscal intermediary (FI), carrier, utilization review committee, provider, or physician that the services were not covered or that similar or reasonably comparable services were not covered. Include a copy of the written notice in the reconsideration notice; and

    - The provider and/or physician had prior knowledge that the services furnished were not covered or that similar or reasonably comparable services were not covered based on experience, actual notice, or constructive notice. This knowledge is based upon the provider's receipt of CMS/QIO/FI/carrier notices (such as manual issuances, bulletins, or other written guides or directives), medical review screening criteria specific to the condition of the beneficiary for whom the furnished services are at issue, or the provider's knowledge of what are considered acceptable standards of practice by the local medical community. Provide specific references and dates in the provider's and physician's rationale (e.g., Bulletin #200, issued September 30, 1990).

- For denials based on circumvention of PPS, explain that the limitation on liability provisions under §1879 do not apply, that the hospital is liable for the denied charges, and that the beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare (see Exhibit 7-50);

- A statement regarding the indemnification of the beneficiary for provider and/or physician services when the beneficiary has been found not liable (see §§7115C.8 and 9) (Include only if the initial denial is upheld or partially reversed. Do not include in circumvention of PPS denials);

- If the beneficiary, provider, and/or physician has been found not liable, specify that the beneficiary is responsible only for payment of any deductible, coinsurance, and convenience services and items normally not covered by Medicare for the denied period;

- If the provider and/or physician has been found liable and the beneficiary has been found not liable, specify that the beneficiary is responsible only for payment of any convenience services and items normally not covered by Medicare for the denied period;

- Include the name, address, and telephone number of the FI and/or carrier where the beneficiary can file a request for indemnification;

- Inform the beneficiary that if a request for indemnification is filed, a copy of the denial notice, a copy of the bill for services, and a copy of the payment receipt from the provider or any other evidence showing that the beneficiary paid the provider must be provided to the FI or carrier;

- A statement regarding future liability (See §7115.C.10) (Include only if the initial denial is upheld or partially reversed. Do not include in circumvention of PPS denials);

- A complete discussion about further appeal rights of all parties (i.e., right to request a hearing before an ALJ) (Include only if the initial denial is upheld or partially reversed);

- Make it clear that beneficiaries may appeal the reasonableness, medical necessity, or appropriateness of services furnished or proposed to be furnished, the appropriateness of the setting in which the services were or are proposed to be furnished, or whether they are liable for payment under §1879 of the Act (Limitation on Liability). The provider and physician may only request a hearing on the issue of knowledge under §1879. Providers may request a hearing on the issue of circumvention of PPS (see §7410.A);

- State the minimum amount that must be in controversy to appeal your reconsideration determination (see §7500);

- State that a written request for appeals (ALJ hearings) must be filed within 60 calendar days after receipt of a reconsideration determination;

- State that the request should include: the beneficiary's name, Medicare *beneficiary identifier*, where and when the services were received, the reason for dissatisfaction with your determination, any additional evidence the beneficiary, provider or physician wishes to submit, and a copy of the reconsideration notice;

- State that a beneficiary may send an ALJ hearing request to you, any SSA District Office, any Office of Hearings and Appeals (OHA), or a Railroad Retirement Board Office (if eligible) and that a provider or practitioner may send an ALJ hearing request to you or OHA (Do not include in circumvention of PPS denials);

- A statement regarding the beneficiary's or his/her representative's right to legal representation (Include only if the initial denial is upheld or partially reversed. Do not include in circumvention of PPS denials). Use the following language without alteration:

    - "If you want help with your appeal of this denial determination, you can have a friend, lawyer or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify."

- A statement regarding the beneficiary's or his/her representative's right to examine or receive a copy of the complete medical/clinical record (Include only if the initial denial is

upheld or partially reversed. Do not include in circumvention of PPS denials). Use the following language without alteration:

- "You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information."

- The signature of the medical director or designated physician (see §7115.C.15).

Notice to Payers -- Provide prompt written or electronic notification to the appropriate Medicare FI or carrier of a reconsidered determination when the initial denial and/or liability determination is partially or totally reversed. Include the name of the beneficiary, the *Medicare beneficiary identifier*, the name of the provider and physician, date of admission, and dates of services, if any, for which Medicare payment will not be made.

H. Record of the Reconsideration

Maintain the record (i.e., file) of your reconsideration until the later of 4 years after the date on the notice of your determination or completion of litigation and the passage of the time period for filing all appeals.

The record (file) must include:

- The initial denial determination and its basis (i.e., all documents associated with the determination);
- A copy of the initial denial notice;
- Documentation of the date of the receipt of the parties' request for reconsideration;
- Evidence submitted by the parties in support of the reconsideration request;
- The basis for the reconsidered determination;
- A copy of the reconsideration notice; and
- Documentation of when the initial denial and reconsideration notices were given/mailed out to the parties (This may be written in a separately kept log).

7440 - Circumvention of Prospective Payment System (PPS)

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Circumvention of Prospective Payment System (PPS) is a hospital action that results in the unnecessary admission or multiple admissions of an individual entitled to benefits under Medicare Part A. §1886(f)(2) of the Act provides that the Secretary determines, although based upon information supplied by the QIO, the prohibited actions have taken place, and the Secretary denies payment. Therefore, the provisions of §1869 of the Act and 42 CFR 405, which deal with appeals from non-QIO payment denials, are applicable and provide for ALJ, Appeals Council, and judicial review.

Under the Medicare program, circumvention of PPS denials are considered to be initial denial determinations that give further reconsideration and appeal rights to hospitals. Therefore, a hospital dissatisfied with your initial denial determination for circumvention of PPS may request a reconsideration regardless of the amount in controversy (See 42 CFR 405.710(b)). Do not notify the beneficiary or physician of your reconsideration determination (See §7430.G.1 for reconsideration notice requirements) (See Exhibit 7-50).

Section 1886(f)(2) of the Act is directed only to hospitals that are reimbursed under PPS. Because physicians are not paid for services under PPS, a physician does not have an independent right to appeal an adverse determination under this section. The appeal right belongs to the hospital. The hospital may appoint the physician to act as its representative for an appeal or may call a physician as a witness if the appeal goes to a hearing before an ALJ. Although the physician(s) who provided the services during the denied Part A stay do not receive a copy of your denial notice, they do receive notice when the associated Part B payments are denied. Then he/she may separately appeal the denial of Part B services related to the Part A denial if he or she has accepted assignment of the claim from the beneficiary.

Limitation on liability under §1879 of the Act does not apply to Part A denials for circumvention of PPS. If, however, the Part B services associated with the Part A denial are also denied, limitation on liability may apply.

A. Listing of Documentation Required for Hearing

Obtain the following documentation before you forward the file to OHA. If any of the evidence deemed necessary is not in existence, or is otherwise unobtainable, fully document this and explain.

- Medical Records -- The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services (See 42 CFR 482.24(c)). If possible, send a copy of

the entire medical record. Generally, the medical record contains the following documents:

- Consent to treatment statement;
- Consultations, if any;
- Demographics sheet (e.g., face sheet);
- Discharge summary;
- Discharge/transfer instructions;
- Emergency department records, if any;
- Graphic sheets;
- History and physical;
- Intake/output sheets;
- IV flow sheets, if any;
- Laboratory results (e.g., blood work, urine tests);
- Medication records;
- Nursing assessments;
- Operative/procedural consent to treatment statement, if any;
- Operative reports, if any;
- Physician attestation statement;
- Physician's orders;
- Problem list, if any;
- Progress notes (e.g., physician, nurse, other multi-disciplined practitioners);
- Rehabilitation reports, if any; and
- Test results (e.g., X-rays, MRIs, EKGs, CAT scans), if any.

- QIO Documents -- Include the following documents from your files:

  - Notice of initial denial determination, including a determination on limitation on liability (See §7115 for denial notice content);

  - Request for reconsideration (See §7430.G.1 for reconsideration notice content);

  - Request for hearing; and

  - Reconsideration determination notice including a determination on limitation on liability. To support your reconsideration determination, include the following information:

    - The professional qualifications and experience of the physician reconsideration reviewer. Explain that in accordance with regulations governing disclosure of confidential QIO information you may not reveal the identity of the reviewer unless he/she gives his/her consent (See 42 CFR 480 and §7430); and

    - Rationale supporting the determination with the corresponding statute/regulation. Provide your rationale in your reconsideration letter so that it may be taken into consideration by OHA. It is not sufficient to add an explanation to the hearing file.

To request a hearing, the beneficiary or his/her representative (whose appointment has been properly documented) may send a letter or submit OHA's Form CMS-5011-U6, Request for Hearing (see Exhibit 7-62). If a beneficiary submits a letter requesting a hearing without Form CMS-5011-U6, fill out Form CMS-5011-U6 and attach the incoming letter and the form to a letter to OHA that includes the following statement: "See attached letter dated." Staple the letter and the postmarked envelope in which it arrived to the hearing request form. You are not responsible for completing Form SSA-1696-U4, Appointment of Representative. Instead, check the appropriate blank under Item 19A on Form CMS-384, QIO Case Summary, indicating whether a completed beneficiary representative form is on file.

NOTE: Upon receipt of a request for hearing, it is imperative that you date-stamp the request. A request is considered filed on the date it is postmarked (see 42 CFR 478.42(b)(3)). Also, retain a copy of the envelope in which the request for hearing was received in order to have a record of the exact date a request was filed.

- Other Pertinent Documents -- Include the following pertinent documents in your file:

  - Hospital denial notice, preadmission/pre-procedure denial notice and the physician's response to the pre-denial notice. These documents may be the only records in the file if the beneficiary was never subsequently admitted to the hospital or the procedure was never performed following a preadmission/pre-procedure denial;

- Copies of prior denial notices that involve the same or reasonably comparable conditions. These are especially important for appeals made under the limitation on liability provision;

- Copies of the laws and regulations not otherwise referenced in your determination on which you relied;

- Copies of relevant review criteria with a statement explaining that you developed the review criteria with the assistance of specialty physicians from your State and that they are medically recognized indicators of care that reflect local standards of medical practice. Also, include a copy of CMS' generic quality screens that have been applied to the case, if appropriate;

- Copies of the actual document/bulletin/Memorandum of Understanding (MOU) containing the information given to the provider community. Reference actual documents sent to the hospitals, which may include relevant pages of the QIO Manual; and

- All appropriate billing forms and current benefit data from the claim history. If billing forms and benefit data are not available in the file, request that the Fiscal Intermediary (FI) send this information to the appropriate hearing office (See Exhibits 7-63 and 7-64). Do not hold the hearing folder if you only need FI data. Forward the folder directly to OHA.

NOTE: These documents support your determination. ALJs rule based on preponderance of evidence. The parties to the appeal can bring medical specialists and lawyers to the hearing to establish evidence on their behalf (Party is legally defined as "a person or group involved in a legal proceeding"). However, because neither CMS nor the QIO is a party, ensure that the file forwarded to OHA is as complete as possible.

B. Assembling the Hearing Claim File

Place all hearing requests in folders before you send them to the hearing office. Each folder must contain the beneficiary's *Medicare beneficiary identifier (Mbi)* on one line followed directly underneath by the surname, first name, and middle initial (if known). All claims material that pertains to services in question, including the envelope in which the request for hearing was received, must be profiled in this folder in chronological order by type of evidence (e.g., nurse's notes, physician's orders) with the most current material on top.

To provide the ALJ with a concise overview of your determination, add a sheet with the qualifications and experience of the physician reconsideration reviewer and his/her rationale supporting the determination with the corresponding statute/regulation.

Include documents to support your limitation on liability determination.

7520 - Assembling the Hearing Claim File

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Complete documentation is vital. It is the foundation upon which to make and sustain determinations. Inadequate documentation leads to improper and inconsistent determinations, delays in the appeals process, and reversals at higher appellate levels. Therefore, when assembling the case file, make sure you include all pertinent material.

Files furnished for ALJ hearings must provide specific rationale supporting your determination (Cite applicable sections of the statute and regulations and/or published precedents). The statute, regulations, CMS rulings, and national coverage determinations are binding on ALJs. It is important to cite appropriate regulations because these coincide with the ALJ frame of reference. CMS manual instructions are not binding on ALJs unless the statute or regulations specifically incorporates them.

National coverage determinations are found in the Coverage Issues Manual.

The CMS Rulings contain precedent case dispositions, statements of policy, and interpretations of the law and regulations, which you are to follow. CMS Rulings are binding on all CMS components, the Provider Reimbursement Review Board, and ALJs who hear Medicare appeals. These decisions promote consistency in interpretation of policy and adjudication of disputes.

A. Listing of Documentation Required for Hearing

Obtain the following documentation before you forward the file to OHA. If any of the evidence deemed necessary is not in existence, or is otherwise unobtainable, fully document this and explain.

- Medical Records -- The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medication and services (See 42 CFR 482.24(c)). If possible, send a copy of the entire medical record. Generally, the medical record contains the following documents:

    - Consent to treatment statement;

    - Consultations, if any;

    - Demographics sheet (e.g., face sheet);

- Discharge summary;
- Discharge/transfer instructions;
- Emergency department records, if any;
- Graphic sheets;
- History and physical;
- Intake/output sheets;
- IV flow sheets, if any;
- Laboratory results (e.g., blood work, urine tests);
- Medication records;
- Nursing assessments;
- Operative/procedural consent to treatment statement, if any;
- Operative reports, if any;
- Physician attestation statement;
- Physician's orders;
- Problem list, if any;
- Progress notes (e.g., physician, nurse, other multi-disciplined practitioners);
- Rehabilitation reports, if any; and
- Test results (e.g., X-rays, MRIs, EKGs, CAT scans), if any.

➢ QIO Documents **--** Include the following documents from your files:

- Notice of initial denial determination, including a determination on limitation on liability (See §7115 for denial notice content);
- Request for reconsideration (See §7430.G.1 for reconsideration notice content);
- Request for hearing; and

- Reconsideration determination notice including a determination on limitation on liability. To support your reconsideration determination, include the following information:

    - The professional qualifications and experience of the physician reconsideration reviewer. Explain that in accordance with regulations governing disclosure of confidential QIO information you may not reveal the identity of the reviewer unless he/she gives his/her consent (See 42 CFR 480 and §7430); and

    - Rationale supporting the determination with the corresponding statute/regulation. Provide your rationale in your reconsideration letter so that it may be taken into consideration by OHA. It is not sufficient to add an explanation to the hearing file.

To request a hearing, the beneficiary or his/her representative (whose appointment has been properly documented) may send a letter or submit OHA's Form CMS-5011-U6, Request for Hearing (See Exhibit 7-62). If a beneficiary submits a letter requesting a hearing without Form CMS-5011-U6, fill out Form CMS-5011-U6 and attach the incoming letter and the form to a letter to OHA that includes the following statement: "See attached letter dated." Staple the letter and the postmarked envelope in which it arrived to the hearing request form. You are not responsible for completing Form SSA-1696-U4, Appointment of Representative. Instead, check the appropriate blank under Item 19A on Form CMS-384, QIO Case Summary, indicating whether a completed beneficiary representative form is on file.

NOTE: Upon receipt of a request for hearing, it is imperative that you date-stamp the request. A request is considered filed on the date it is postmarked (See 42 CFR 8.42(b)(3)). Also, retain a copy of the envelope in which the request for hearing was received in order to have a record of the exact date a request was filed.

- Other Pertinent Documents -- Include the following pertinent documents in your file:

    - Hospital denial notice, preadmission/pre-procedure denial notice and the physician's response to the pre-denial notice. These documents may be the only records in the file if the beneficiary was never subsequently admitted to the hospital or the procedure was never performed following a preadmission/pre-procedure denial;

    - Copies of prior denial notices that involve the same or reasonably comparable conditions. These are especially important for appeals made under the limitation on liability provision;

    - Copies of the laws and regulations not otherwise referenced in your determination on which you relied;

- Copies of relevant review criteria with a statement explaining that you developed the review criteria with the assistance of specialty physicians from your State and that they are medically recognized indicators of care that reflect local standards of medical practice. Also, include a copy of CMS' generic quality screens that have been applied to the case, if appropriate;

- Copies of the actual document/bulletin/MOU containing the information given to the provider community. Reference actual documents sent to the hospitals, which may include relevant pages of the QIO Manual; and

- All appropriate billing forms and current benefit data from the claim history. If billing forms and benefit data are not available in the file, request that the Fiscal Intermediary (FI) send this information to the appropriate hearing office (See Exhibits 7-63 and 7-64). Do not hold the hearing folder if you only need FI data. Forward the folder directly to OHA.

NOTE: These documents support your determination. ALJs rule based on preponderance of evidence. The parties to the appeal can bring medical specialists and lawyers to the hearing to establish evidence on their behalf (Party is legally defined as "a person or group involved in a legal proceeding"). However, because neither CMS nor the QIO is a party, ensure that the file forwarded to OHA is as complete as possible.

B. Assembling the Hearing Claim File

Place all hearing requests in folders before you send them to the hearing office. Each folder must contain the beneficiary's *Medicare beneficiary identifier (Mbi)* on one line followed directly underneath by the surname, first name, and middle initial (if known). All claims material that pertains to services in question, including the envelope in which the request for hearing was received, must be profiled in this folder in chronological order by type of evidence (e.g., nurse's notes, physician's orders) with the most current material on top.

To provide the ALJ with a concise overview of your determination, add a sheet with qualifications and experience of the physician reconsideration reviewer and his/her rationale supporting the determination with the corresponding statute/regulation.

Include documents to support your limitation on liability determination.

Exhibit 7-23 - Record Not Submitted Timely Denial Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Use for retrospective admission denials when the medical record (or itemized bill for cost outliers) is not submitted timely by the hospital.

- Opportunity for discussion does not apply.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration does not apply.

NOTE: For inpatient hospital services furnished on or after January 1, 1989, through December 31, 1989, delete reference to the beneficiary's:

- Responsibility for payment of the coinsurance; and
- Utilization of the benefit period.

Record Not Submitted Timely Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We have denied Medicare payment for your admission of (date) to (provider name) for (specify the procedure/treatment or condition/services). This denial is due solely to the hospital's failure to submit your (select: medical record; or itemized bill; or medical record and itemized bill) as requested by us. This information is necessary for us to complete review of this claim.

Medicare will not pay the hospital for this admission. However, you are not responsible for payment of the denied services except for any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare. If you have paid the hospital for any of the denied services other than those amounts just mentioned, arrangements can be made to pay you back. Please contact the Fiscal Intermediary (FI) at:

FI Name
Address
Telephone Number

You must make your written request for payment within 6 months of the date of this notice and provide the FI with the following documents:

- A copy of this notice;
- The bill you received for the services; and
- The payment receipt or any other evidence (e.g., canceled check) showing that you have paid for the denied services.

Be aware that the days you spent as an inpatient will be subtracted from the total number of days available to you in this benefit period. Your case can be reopened when the necessary information is submitted by the hospital. You will be notified of the decision resulting from this review.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-24 - Billing Error Denial Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Use for retrospective admission denials when review cannot be completed due to a provider billing error (e.g., incorrectly billed an uninterrupted stay as two separate admissions). Use this notice if you are responsible for notification of billing errors as a result of your agreements with the FI(s) and provider.

- Opportunity for discussion does not apply.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration does not apply.
- Do not notify the beneficiary.

NOTE: For inpatient hospital services furnished on or after January 1, 1989, through December 31, 1989, delete reference to the beneficiary's responsibility for payment of the coinsurance.

Billing Error Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ______________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We have denied Medicare payment for the above admission of (date) for (specify the procedure/treatment or condition/services). In reviewing this admission, an error in billing was discovered which precludes us from completing review of this claim. Our determination is based on the following: (Relate discussion to specific billing error).

Medicare will not pay the hospital for this admission. The beneficiary or his/her representative is only responsible for payment for any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

This case can be reopened when a corrected bill is submitted by the hospital to the Fiscal Intermediary (FI), at which time the FI will resubmit the case to us to complete review.

Sincerely,

Medical Director (or designated physician)
Chief Executive Officer, etc., as appropriate

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-25 - Preadmission Denial Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Use only for denials of services furnished prior to admission to the facility.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration applies (See Exhibit 7-21).

Preadmission Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your proposed admission of (date) (specify, if known: "to" (name of provider)) for (specify the procedure/treatment or condition/services).

Prior to reaching this decision, we gave your physician (if known: and the hospital) an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a full discussion of the specific reason(s) for denial).

Medicare will not pay for your proposed admission if you and your physician decide you should be admitted to the hospital. We are also advising your physician (if known: and the hospital) of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: For denials of provider services only, insert: “Therefore, you will be responsible for payment of all costs for the hospital services you receive except for those covered services which can be paid for by Medicare Part B.”

NOTE: For denials of provider and related physician services, insert: "Therefore, you will be responsible for payment of all costs for the hospital and related physician services you receive except for those covered services which can be paid for by Medicare Part B."

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

Use reconsideration paragraph under Condition I.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-26 - Admission Denial Model Notices

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for retrospective admission denials (PPS and non-PPS hospitals) based on inappropriate setting, medically unnecessary, or custodial care. Revise accordingly for denials involving direct admission for NF swing bed services with or without an admission HINN.

Condition II: Use for retrospective denials based on inappropriate setting, medically unnecessary, or custodial care involving "deemed" admission date cases.

For both conditions:

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Admission Denial Model Notices:

Condition I: Use for retrospective admission denials (PPS and non-PPS hospitals) based on inappropriate setting, medically unnecessary, or custodial care. Revise accordingly for denials involving direct admission for swing bed services with or without an admission HINN.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ______________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services).

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition II: Use for retrospective denials based on inappropriate setting, medically unnecessary, or custodial care involving "deemed" admission date cases.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that the services you received from (date) through (date) are denied for Medicare payment. We have also determined that the services you received for (specify the procedure/treatment or condition/services) beginning (date) were medically necessary and appropriate. Therefore, Medicare will pay for hospital services from (date) through (date).

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-27 - Continued-stay Denial Notices

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Summary of Continued-stay Denial Notices Conditions I-VIII:

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for concurrent denials when the provider requests review of a proposed continued-stay HINN.

Condition II: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a continued-stay HINN (includes SNF swing bed continued-stay denials).

Condition III: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

Condition IV: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

Condition V: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

Condition VI: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

Condition VII: Use for concurrent denials not involving a continued-stay HINN.

Condition VIII: Use for retrospective denials with or without a continued-stay HINN (For PPS cases without a continued-stay HINN, this condition only applies to denials involving the day outlier period of the stay).

For all conditions:

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Continued-stay Denial Model Notices:

Condition I: Use for concurrent denials when the provider requests review of a proposed continued-stay HINN.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Based on (name of provider)'s request, our physicians have reviewed your admission on (date) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. However, the services you are currently receiving are not covered by Medicare. Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Use limitation of liability paragraph in Exhibit 7-20 under Condition VI.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition II: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a continued-stay HINN (includes SNF swing bed continued-stay denials).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name

Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On (date of request for review of HINN), you requested that we review your case because you received, with your physician's concurrence, a notice of non-coverage from (name of provider) on (date). Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. We agree, however, with your physician and the hospital that for the reasons specified below, as of (date specified by QIO under Condition VI or VII of limitation of liability paragraph), the services you are currently receiving are not covered by Medicare because (reason for denial). Therefore, any inpatient hospital services you receive beginning (date specified by QIO under Condition VI or VII of limitation of liability paragraph) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through telephone discussions with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select limitation of liability paragraph in Exhibit 7-20 under Condition VI or VII.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You

may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition III: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ______________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Based on (name of provider)'s request, our physicians have reviewed your admission for acute care services on (date) for (specify the procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate but that you no longer require acute care services beginning (date of first non-covered acute care day). The care that you need now is not covered by Medicare. Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital. After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

We notified you on (date of (telephone) notification) that beginning on (date of the day following the date of receipt of the QIO notification) you would be responsible for payment of all costs for hospital services you receive except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to (date of the day following the date of receipt of the QIO notification), you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and hospital of this denial. You should discuss with your physician other arrangements for any further health care you may now require.
Upon receipt of this notice, you will continue to be responsible for payment for denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may require in the future.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital

Physician
FI
Carrier

Condition IV: Use for concurrent denials when the provider requests review of a proposed combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Based on (name of provider)'s request, our physicians have reviewed your admission on (date) for (specify the procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate, but that you no longer require acute care services beginning (date of first non-covered acute care day). However, we have determined that you still require the type of hospital services which are furnished in a Skilled Nursing Facility (SNF) beginning (specify date of first SNF swing bed day). These services are known as SNF swing bed services. Medicare will pay for your SNF swing bed services if you have not used up all your SNF benefit days.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

We notified you on (date of (telephone) notification) of our determination that you no longer required acute care services, but that you do still require SNF services. Therefore, you are responsible only for payment of any amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare applicable to the acute care and SNF services received during your entire hospital stay.

We are also advising your physician and hospital of this determination.

Upon receipt of this notice, you will be responsible for payment for denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may require in the future. Should the need arise for further acute care, we encourage you to discuss arrangements for your health care with your physician.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition V: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving NF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On (date of request for review of HINN), you requested that we review your case because you received a notice of non-coverage from (name of provider) on (date), and you believe you still require acute care services. Our physicians have reviewed your admission of (date of acute care admission) for (specify the procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate but that you no longer require acute care services beginning (date of first non-covered acute care day). The care that you need now is not covered by Medicare. Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).
We notified you on (date of (telephone) notification) that beginning on (date of the day following the date of receipt of the HINN) you would be responsible for payment of all costs for hospital services you receive except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to (date of the day following the date of receipt of the HINN), you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and hospital of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment of denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may require in the future.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition VI: Use for concurrent denials when the beneficiary requests an immediate or non-immediate review of a combined HINN (i.e., acute care continued-stay denial involving SNF swing bed services).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On (date of request for review of HINN), you requested that we review your case because you received a notice of non-coverage from (name of provider) on (date), and you believe you still require acute care services. Our physicians have reviewed your admission of (date of acute care admission) for (specify the acute care procedure/treatment or condition/services). We have determined that your admission for acute care services was medically necessary and appropriate, but that you no longer required acute care services beginning (date of first non-covered acute care day). However, we have determined that you still require the type of hospital services which are furnished in a Skilled Nursing Facility (SNF) beginning (specify date of first SNF swing bed day). These services are known as SNF swing bed services. Medicare will pay for your SNF swing bed services if you have not used up all your SNF benefit days.

Prior to reaching this decision, we considered the information provided through a telephone discussion with (insert either "you" or the name of the representative to whom you spoke) on (date of solicitation of views), and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

We notified you on (date of (telephone) notification) of our determination that you no longer require acute care services, but that you do still require SNF services. Therefore, you are responsible only for payment of any amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare applicable to the acute care and SNF services received during your entire hospital stay.

We are also advising your physician and hospital of this determination.

Upon receipt of this notice, you will be responsible for payment for denied acute care services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate acute hospital care you may

require in the future. Should the need arise for further acute care, we encourage you to discuss arrangements for your health care with your physician.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier
Condition VII: Use for concurrent denials not involving a continued-stay HINN.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date

Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ______________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. However, the services you are currently receiving are not covered by Medicare. Therefore, any inpatient hospital services you receive beginning (date) will not be paid by Medicare.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Use limitation of liability paragraph in Exhibit 7-20 under Condition VIII.

Use reconsideration paragraph in Exhibit 7-21 under Condition II.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.
You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition VIII: Use for retrospective denials with or without a continued-stay HINN (For PPS cases without a continued-stay HINN, this condition only applies to denials involving the day outlier period of the stay).

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We have determined that your admission was medically necessary and appropriate. However, the inpatient hospital services you received beginning (specify denied date(s)) are denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-28 - Procedure Denial Model Notices

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for retrospective procedure denials.

If the beneficiary required hospital inpatient services but the procedure is not medically necessary, then only the procedure is denied. Use the procedure denial model notice.

- Opportunity for discussion applies.

- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).

- Reconsideration applies (See Exhibit 7-21).

Condition II: Use for preadmission denials.

If the proposed procedure is non-covered and is the only reason for the admission, then the admission is denied. Use the preadmission denial model notice (See Exhibit 7-25).

Condition III: Use for retrospective admission denials.

If the procedure is non-covered and is the only reason for the admission, then the admission is denied. Use the admission denial model notice (See Exhibit 7-26, Condition I).

Condition IV: Use for concurrent or retrospective continued-stay denials.

If the beneficiary required admission initially, but remain(s/ed) in the facility for the proposed procedure only, then the continued-stay is non-covered and is denied. Use the appropriate continued-stay denial model notice (See Exhibit 7-27).

NOTE: For any of the above conditions, if the denial is for a procedure that cannot be repeated (e.g., total removal of an organ), do not use the future liability paragraph: "Upon receipt..."

Procedure Denial Model Notices:

Condition I: Use for retrospective procedure denials.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of

____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We determined that your admission was medically necessary and appropriate. However, the (name of procedure) that was performed on (date) is denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under condition I, III, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 29 - Day Outlier Denial Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Use for retrospective day outlier denials (PPS hospitals) and retrospective partial admission denials (non-PPS hospitals) based on inappropriate setting, medically unnecessary, or custodial care. This applies to those cases where days are carved-out from the outlier period of a PPS admission or from a non-PPS admission. In those cases where the denial is for an uninterrupted period (i.e., beginning at a specified date through discharge), use the appropriate continued-stay denial model notice (See Exhibit 7-27).

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Day Outlier Denial Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet

medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We determined that your admission was medically necessary and appropriate. However, the inpatient hospital services you received (specify denied date(s)) for a total of (number) day(s) are denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II, IV, V, IX, or X.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-30 - Cost Outlier Denial Model Notices

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Identify the denial condition, and use the appropriate model notice.

Condition I: Use for retrospective denials of services or items based on inappropriate setting or medically unnecessary.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Condition II: Use for retrospective denials of services or items based on duplicative billing, or for services not actually furnished or not ordered by the physician.

- Opportunity for discussion does not apply.
- Limitation of liability (§1879 of the Act) does not apply.
- Reconsideration does not apply.
- Do not notify the beneficiary.
- For inpatient hospital services furnished on or after January 1, 1989, through December 31, 1989, delete reference to the beneficiary's responsibility for the coinsurance payment.

Cost Outlier Denial Model Notices:

Condition I: Use for retrospective denials of services or items based on inappropriate setting or medically unnecessary.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name

Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed your admission of (date) to (name of provider) for (specify the procedure/treatment or condition/services). We determined that your admission was medically necessary and appropriate. However, certain inpatient hospital service(s) and item(s) you received are denied for Medicare payment.

Prior to reaching this decision, we gave your physician and the hospital an opportunity to discuss your case.

The specific service/item(s) are as follows:

Specific Service/Item
Date of Service/Item
Charges

After a review of your medical record and any additional information provided, we determined that (give a complete, fact-specific discussion of why admitted, care received, reason Medicare is denying, etc.).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under Condition I, II (cost outlier without a physician component denials based on inappropriate setting or medically unnecessary), III (cost outlier with a physician component denials based on medically unnecessary), IV, or V.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the

records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition II: Use for retrospective denial of services or items based on duplicative billing, or for services not actually furnished or not ordered by the physician.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physicians have reviewed the above admission of (date) for (specify the procedure/treatment or condition/services). We have determined that the admission was medically necessary and

appropriate. However, certain inpatient hospital service/item(s) are denied for Medicare payment.

The specific services/items are as follows:

Specific Service/Item
Date of Service/Item
Charges

After a review of the medical record, we determined that (relate discussion to the specific reason for denial).

- Duplicative billing occurred;
- Services/items not actually furnished; or
- Services/items were not ordered by the physician.

Medicare will not pay the hospital for the denied services. The beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible and coinsurance related to covered services and any amounts for convenience services and items normally not covered by Medicare.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-31 - DRG Changes as a Result of DRG Validation Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Use when retrospective review results in changes that affect the DRG assignment.

- Opportunity for discussion applies.
- Re-review applies (Reconsideration does not apply).
- Do not notify the beneficiary.

DRG Changes as a Result of DRG Validation Model Notice:

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We are also required to perform Diagnostic Related Group (DRG) validation on all cases selected for review to ensure that the diagnostic and procedural codes reported by the provider and resulting in the DRG assignment by the Fiscal Intermediary (FI) match both the documentation in the medical record and the physician's attestation.

We have reviewed the above admission of (date) for (specify the procedure/treatment or condition/services). An opportunity to discuss this case was given to the provider and the physician.

We have determined that the admission was medically necessary and appropriate. However, based on a review of the medical record and any other information available, we have changed the following code(s):

- Hospital submitted code(s) and narrative description
- QIO coding change(s) and narrative description

This has resulted in a change in the DRG assignment from (__________) to (__________).

After a review of the medical record and any additional information provided, we determined that (relate discussion to the specific reason for the change(s)).

If the provider or physician disagrees with our determination, either party may request a re-review. You must submit your request for a re-review in writing within 60 days from receipt of this notice directly to us at:

QIO Name
Address
Telephone Number

This information is being reported to the FI for a payment adjustment.

Sincerely,

Medical Director (or designated physician)
Chief Executive Officer, RRA, or ART, as appropriate

ccs:
Physician
FI
Carrier

Exhibit 7-32 - Outpatient/Ambulatory Surgery Denial Model Notices

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Identify the denial condition, and use the appropriate model notice. This applies to hospital outpatient settings and ambulatory surgical centers.

Condition I: Use for pre-procedure denials.

- Opportunity for discussion applies.

- Limitation of liability (§1879 of the Act) does not apply.

- Reconsideration applies (See Exhibit 7-21).

Condition II: Use for post-procedure denials (either prepayment or post-payment). Use this model letter if the procedure performed is non-covered as not medically necessary.

- Opportunity for discussion applies.
- Limitation of liability (§1879 of the Act) applies (See Exhibit 7-20).
- Reconsideration applies (See Exhibit 7-21).

Outpatient/Ambulatory Surgery Denial Model Notices:

Condition I: Use for pre-procedure denials.

YOUR LETTERHEAD

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of _____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your proposed surgery of (date) (specify, if known: at (name of provider)) for (specify the surgical procedure).

Prior to reaching this decision, we gave your physician (if known, add: and the provider) an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (Relate discussion to the specific reason(s) for denial).

Medicare will not pay for your proposed surgery if you and your physician decide you should proceed with the surgery. Therefore, you will be responsible for payment of all costs for the services you receive.

We are also advising your physician (if known, add: and the provider) of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate care you may require in the future.

Use reconsideration paragraph in Exhibit 7-21 under Condition I.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Condition II: Use for post-procedure denials (either prepayment or post-payment).

YOUR LETTERHEAD

Date of Notice

Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our physician reviewers have denied Medicare payment for your surgery of (date) at (facility name) for (specify the surgical procedure).

Prior to reaching this decision, we gave your physician and the provider an opportunity to discuss your case.

After a review of your medical record and any additional information provided, we determined that (Relate discussion to the specific reason(s) for denial).

Select appropriate limitation of liability paragraph in Exhibit 7-20 under condition XI, XII, or XIII.

Use reconsideration paragraph in Exhibit 7-21 under Condition III.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director (or designated physician)

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-33 - Continued-stay Denial Completed Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

YOUR LETTERHEAD:
Peer System, Inc.
1000 Pine Drive
Baltimore, Maryland 12345
410-555-5555

Date of Notice: August 12, 1990
Name of Patient: John Doe
Address: 200 Cherry Drive
City, State, and Zip Code: Somewhere, MD 00000

Medicare beneficiary identifier: *0000-000-0000*
Provider Name: Nowhere Hospital
Provider Number: 21-0000
Medical Record Number (if known): 2222
Admission Date: August 1, 1990
Physician Name: John Smith, M.D.

Dear Mr. Doe:

The Peer System, Inc., is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of Maryland. By law, we review Medicare cases to determine if the services meet

medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

On August 11, you requested that we review your case because you received, with your physician's concurrence, a notice of non-coverage from Nowhere Hospital on August 10. Our physicians have reviewed your admission of August 1 to Nowhere Hospital for medical and surgical treatment related to gallstones. We have determined that your admission was medically necessary and appropriate. We agree, however, with your physician and the hospital that for the reasons specified below, as of August 13, the services you are currently receiving are not covered by Medicare because they are no longer medically necessary in the hospital inpatient setting and they can be given safely and effectively outside of a hospital. Therefore, any inpatient hospital services you receive beginning after noon, August 13, will not be paid by Medicare.

Prior to reaching this decision, we considered the information provided through telephone discussions with you on August 12, and any comments received from your physician and the hospital.

After a review of your medical record and the information provided, we determined that you no longer require acute care in a hospital setting. The medical records show that you were admitted on August 1 with complaints of nausea and vomiting of several days duration. After receiving intravenous fluid replacement, a decision was made to remove your gall bladder, which was accomplished on August 3. By August 7, you were no longer taking injections for pain control and were tolerating a regular diet. By August 8, you were up and about in your room and the hall. On August 9, your physician removed your stitches and noted that your incision was well healed with no drainage. By August 10, you were receiving only your oral diuretic, the dosage being the same as when you were admitted. Thus, by the time the hospital gave you the notice of non-coverage, you required only the administration of an oral medication.

We notified you by telephone on August 12, of our determination that the services you are receiving are not covered by Medicare and that if you decided to remain in the hospital after 12 noon on August 13, you would be responsible for payment of all costs of hospital services you receive after that time except for those covered services which can be paid for by Medicare Part B. If you decide to leave the hospital prior to 12 Noon on August 13, you will be responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and the hospital of this denial. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment for denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

If you disagree with our determination and you decide to remain in the hospital, you, your physician, or hospital may appeal this denial decision, while you are still in the hospital, by requesting an expedited reconsideration through the hospital by telephoning or by writing us at:

Peer System, Inc.
1000 Pine Drive
Baltimore, Maryland 12345
410-555-5555

We will complete our expedited reconsideration and send a written notice to you within three working days.

However, if you don't remain in the hospital after 12 Noon on August 13 or if you remain in the hospital and do not request an expedited reconsideration, you, your physician, or hospital are still entitled to a reconsideration. You must submit your request in writing within 60 days from the receipt of this notice to us at the above address.

You may also make your request to any Social Security Office or Railroad Retirement Office (if you are a Railroad Retirement beneficiary). Your request will be forwarded to us.

As a result of our review, we may reaffirm or reverse our prior denial determination. If we reaffirm the denial determination, you will continue to be responsible for payment of services furnished as specified above. If we reverse the denial determination, you will be refunded any amount collected by the hospital except for payment of deductible, coinsurance, or any convenience services or items normally not covered by Medicare.

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making this denial determination. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

Sincerely,

Medical Director

ccs:
Hospital
Physician
FI
Carrier

Exhibit 7-34 - Circumvention of Prospective Payment System (PPS) Denial Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Use for retrospective Part A denials involving PPS and PPS-excluded admissions and readmissions within the same PPS hospital based on your determination that the services should have been furnished during the first admission or that the discharge and subsequent admission were inappropriate. This also applies to discharges from PPS and PPS-excluded units and subsequent admissions to hospital-based Skilled Nursing Facility (SNF) and SNF swing beds.

- Opportunity for discussion applies.
- Limitation on liability (§1879 of the Act) does not apply.
- Reconsideration applies (See Exhibit 7-50).
- Do not notify the beneficiary or physician.

Circumvention of PPS Denial Model Notice:

(Do not notify the beneficiary or physician).

LETTERHEAD OF THE QIO

Date of Notice
Name of Provider
Address of Provider
City, State, and Zip Code

Patient Name
Medicare beneficiary identifier
Medical Record Number (if known)
First Admission Date
Readmission/Transfer Date

PPS Provider Number
PPS-excluded Provider Number (if known)
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Select paragraph A, B, or C below:

A: Services Should Have Been Furnished During the First Admission

Our physicians have reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent acute care readmission of (date) for (specify the procedure/treatment or condition/services). We have determined that the services furnished were medically necessary and appropriate. However, the services should have been furnished during the first admission. This action is considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital admitted the patient on (date) and again on (date), the hospital received two Medicare payments instead of one. Therefore, we are denying Medicare payment for the readmission of (date of 2nd admission).

B: Inappropriate Transfer From a PPS Unit to a PPS-Excluded Unit (This also applies to similar transfers from a PPS unit to a hospital-based SNF or SNF swing bed).

Our physicians have reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: psychiatric unit, rehabilitation unit, hospital-based Skilled Nursing Facility (SNF), or SNF swing bed) for (specify the procedure/treatment or condition/services). We have determined that the patient was admitted to the acute care hospital even though the medical record shows that the patient only required care in the (select: psychiatric unit, rehabilitation unit, hospital-based SNF, or SNF swing-bed) and a bed was available at the time of the acute care admission. This action is considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date) and subsequently admitted the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we are denying Medicare payment for the admission of (date of 2nd admission).

C: Inappropriate Transfer From a PPS-Excluded Unit to a PPS Unit (This also applies to similar transfers from a PPS-excluded unit to a hospital-based SNF or SNF swing bed).

Our physicians have reviewed the admission of (date) to the (select: psychiatric or rehabilitation) unit for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: acute care hospital, hospital-based SNF, SNF swing bed) for (specify the procedure/treatment or condition/services). We have determined that the admission to the (select: psychiatric or rehabilitation) unit was medically necessary and appropriate and that the patient continued to require (select: psychiatric or rehabilitation) care/services when transferred to the (select: acute care hospital, hospital-based SNF, or SNF swing-bed). This action is considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date) and subsequently admitted the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we are denying Medicare payment for the admission of (date of 2nd admission).

This denial determination is made under §1886(f)(2) of the Social Security Act. This section authorizes a denial of payment under Part A when the Secretary determines, based on information provided by a QIO that a hospital has taken an action, in order to circumvent PPS, which results in unnecessary admissions, multiple admissions of the same individual, or other inappropriate practices.

Prior to reaching this decision, we gave you an opportunity to discuss this case.

After a review of the medical record and any additional information provided, we determined that (Give a complete, fact-specific discussion related to the reason for denial under paragraph A, B, or C).

The limitation on liability provision of §1879 of the Act does not apply to Part A denials issued under §1886(f)(2) of the Act. Therefore, the hospital is liable for the charges of the denied services. The beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare. If the beneficiary or his/her representative has paid the hospital for any of the denied services other than those amounts already mentioned, the hospital is to refund such payment.

If you disagree with our determination, you may appeal this denial decision by requesting a reconsideration. You must submit your request in writing within 60 days from receipt of this notice directly to us at:

QIO Name
Address
Telephone Number

Sincerely,

Medical Director (or designated physician)

ccs:
FI
Carrier

Exhibit 7-40 - Reconsideration Notices -- Hearings Model Paragraphs

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Condition I: Use in your reconsideration notice when you affirm or partially reverse an initial denial determination that was based on medical necessity or appropriateness of setting, or when you affirm your liability determination that the beneficiary knew that the denied services would not be covered by Medicare.

If you disagree with our reconsideration determination, you may request a formal hearing before an Administrative Law Judge (ALJ) of the Social Security Administration's (SSA's) Office of Hearings and Appeals (OHA) under the following conditions:

- If Medicare has denied payment of $200 or more for services determined to be either not medically necessary or not provided at an appropriate level of care; or

- If you do not appeal the denial of Medicare payment on the medical issues listed above and have been found liable for payment of at least $100 of the denied services, and you disagree with our liability determination that you knew or should have known that the denied services were not covered.

If you do not request an ALJ hearing regarding the liability determination, a dissatisfied provider or practitioner may request an ALJ hearing of that liability determination if they are liable for services of $100 or more.

If you wish to have an ALJ hearing, you must submit a written request within 60 calendar days of receipt of this notice. Your written request should include: your name, Medicare *beneficiary identifier*, where and when services were received, the reason for your dissatisfaction with our determination, any additional evidence you might wish to submit, and a copy of this notice.

You may send your written request to:

- Any social security office;
- An office of SSA's OHA;
- An office of the Railroad Retirement Board, if you are eligible; or

- To us at the following address:

QIO Name
Address (including zip code)
Telephone Number

(A provider or practitioner may only send a written request to us or OHA.)

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making our initial denial and reconsideration determinations. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you reside along with your complete address and zip code. If you wish the hearing to be held somewhere other than close to your residence, please note that on the hearing request.

Condition II: Attach this paragraph to the provider/physician copy of the beneficiary reconsideration notice, as appropriate.

According to §1879(d) of the Social Security Act, if the amount in controversy is at least $100.00, a beneficiary who is dissatisfied with the limitation on liability reconsideration determination may obtain an administrative hearing conducted by an ALJ of the OHA of SSA. If the beneficiary chooses not to exercise his or her appeal rights regarding the limitation on liability determination, you (a dissatisfied provider or a dissatisfied practitioner) are entitled to an administrative hearing conducted by an ALJ only addressing the issue of whether you knew or should have known that services would not be covered.

If you wish to have an ALJ hearing regarding the limitation on liability reconsideration determination, you must submit a written request within 60 calendar days of receipt of this notice (unless time is extended for good cause). Your written request should include: beneficiary's name, Medicare *beneficiary identifier*, where and when services were provided, the reason for your dissatisfaction with our determination, any additional evidence you might wish to submit, and a copy of this notice.

You may send your written request to:

- An office of SSA's OHA; or
- To us at the following address:

QIO Name
Address (including zip code)
Telephone Number

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you are located along with your complete address and zip code. If you wish the hearing to be held somewhere other than close to your place of business, please note that on the hearing request.

Exhibit 7-41 - Reconsideration Model Notice -- Preadmission Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name (if known)
Provider Number (if known)
Medical Record Number (if known)
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ______________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for (insert either "an expedited reconsideration" or "a reconsideration"), we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your proposed admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that if you and your physician decided that you should be admitted to the hospital, you would be responsible for payment of all costs for the denied services you received except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your proposed admission if you and your physician decide that you should be admitted to the hospital.

NOTE: If you reverse your initial denial determination, insert: "If admitted, you will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "If admitted, you will be responsible for payment of all costs of the denied services you receive except for those covered services which can be paid for by Medicare Part B."

We are also advising your physician and the hospital of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However,

Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

NOTE: If you reverse your initial denial determination, insert: "If admitted, you will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "If admitted, you will be responsible for payment of all costs of the denied services you receive except for those covered services which can be paid for by Medicare Part B."

Use Model Hearings Paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
Provider
Physician
FI/ carrier (if original denial/liability determination changes)

Exhibit 7-42 - Reconsideration Model Notice -- Admission Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number

Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for a reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) because (use medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your admission.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties.

Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
Provider
Physician
FI/carrier (if original denial/liability determination changes)

Exhibit 7-43 - Reconsideration Model Notice -- Continued-stay Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

(Expedited Reconsideration Within Three Working Days)
(Physician Agrees with HINN)

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number

Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for an expedited reconsideration, we conducted a complete review of your medical record to determine whether our original denial determination was correct.

You received, with your physician's concurrence, a notice of non-coverage from (name of provider) on (date), and requested that we review your hospital stay. A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the physician reviewer agreed with your physician and the hospital that beginning (date of first non-covered acute care day), you no longer required acute care in a hospital setting because (use medical information and rationale contained in the initial denial notice).

On (date of notification), we notified you that we agreed with (name of provider)'s notice of non-coverage, and issued a denial determination. You were advised that if you decided to remain in the hospital, beginning (insert date given in denial notice), you would be responsible for payment of all costs of denied services you received, except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or hospital.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will pay the hospital for the inpatient services you are receiving" or "will not pay the hospital for the inpatient services provided (except for those covered services which can be paid for by Medicare Part B) beginning (date)").

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "Also, the hospital may send you a bill for services provided to you beginning (date)."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

We are also advising your physician and the hospital of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
Provider
Physician
FI/carrier (if original denial/liability determination changes)

Exhibit 7-44 - Reconsideration Model Notice -- Procedure Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the treatment, condition, or services) was medically necessary and appropriate. However, the physician reviewer denied Medicare payment for the (name of procedure) that was performed on (date) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Cite the appropriate statutory and regulatory citations. Give a complete fact-specific discussion of why the patient was admitted, the care received, and the reason Medicare is denying or paying for the procedure). Therefore, we have determined that Medicare (select either "will" or "will not") pay for the (name of procedure) provided on (date), for (amount of dollars). Medicare will pay for the medically necessary care and services you received on admission to (name of provider) from (date of admission) to (date of discharge).

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items not normally covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider
Physician
FI/carrier (if original denial/liability determination changes)

Exhibit 7-45 - Reconsideration Model Notice -- Day Outlier Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the physician reviewer denied Medicare payment for the inpatient hospital services you received (specify denied date(s)) for a total of (number) day(s) because (use medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for the inpatient hospital services you received (specify denied date(s)) for a total of (number) day(s).

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
Provider
Physician
FI/carrier (if original denial/liability determination changes)

Exhibit 7-46 - Reconsideration Model Notice -- Cost Outlier Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ______________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer determined that your admission of (date), to (name of provider) for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the physician reviewer denied Medicare payment for the inpatient hospital service(s) and/or item(s) that you received as follows:

Specific Service/Item

Date Service/Item
Charges

Payment was denied because (use medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or hospital.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for the inpatient hospital service(s) and/or item(s) previously specified.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
Provider
Physician
FI/carrier (if original denial/liability determination changes)

Exhibit 7-47 - Re-review Model Notice -- DRG Changes as a Result of DRG Validation

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

(To provider - do not notify the beneficiary)

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address
City, State, and Zip Code

Medicare beneficiary identifier
Provider Name
Provider Number
Medical Record Number (if known)
Admission Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

We also are required to perform Diagnostic Related Group (DRG) validation on all cases selected for review to ensure that the diagnostic and procedural codes reported by the provider and resulting in the DRG assignment by the Fiscal Intermediary (FI) matches both the documentation in the medical record and the physician's attestation.

As a result of (insert either the name of the provider or physician) (date) request for a re-review, we have conducted a complete review of the medical record to determine whether our original DRG assignment determination was correct.

A reviewer determined that the admission of (date), for (specify the procedure/treatment or condition/services) was medically necessary and appropriate. However, the reviewer changed the following code(s):

Hospital Submitted Code(s) and Narrative Description
QIO Coding Change(s)

This resulted in a change in the DRG assignment from (_________) to (___________).

The codes were changed because (use the reason for change contained in the DRG Validation notice).

Prior to our re-review of the DRG assignment, we gave the physician, (name), and you an opportunity to provide additional information, if you wished.

Based on a thorough re-examination of all the information contained in the medical record and consideration of any additional information provided by the physician and by you, the reviewer determined that the change in the DRG assignment (insert either "was" or "was not") correct because (include a brief statement of the facts of the case and the rationale used in upholding or reversing the initial DRG change).

Therefore, the final results of the DRG re-review are as follows:

QIO Determined Codes and Narrative Description:

Final Determination: DRG ______________

The Social Security Act does not provide for further appeal of this determination.

NOTE: Include the above paragraph only if you uphold your initial DRG change determination.

If you have any further questions, please contact ______________.

Sincerely,

Medical Director (or designated physician,
Chief Executive Officer, RRA, or ART, as appropriate)

ccs:
Physician
FI/carrier (if final DRG determination changes)

Exhibit 7-48 - Reconsideration Model Notice -- Outpatient/Ambulatory Surgery Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

Condition I: Use for pre-procedure denials.

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address of Patient
City, State, and Zip Code

Medicare beneficiary identifier
Facility Name (if known)
Facility Provider Number (if known)
Medical Record Number (if known)
Proposed Surgery Date
Physician Name
Dear:

The (your name) is the Quality Improvement Organization authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of _____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for (insert either "an expedited reconsideration" or "a reconsideration"), we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your proposed surgery of (date), at (name of provider) for (specify the surgical procedure) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that if you and your physician decided that you should proceed with the surgery, you would be responsible for payment of all costs for the denied services you receive except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the provider.

The physician reviewer (insert either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your proposed surgery if you and your physician decide to proceed.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

NOTE: If you uphold your initial denial determination, insert: "You will be responsible for payment of all costs of the denied services you receive."

We also are advising your physician and provider of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate care you may require in the future.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings Paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
Provider
Physician
FI/carrier (if original denial/liability determination changes)

Condition II: Use for post-procedure denials (either prepayment or post-payment).

LETTERHEAD OF THE QIO

Date of Notice
Name of Patient
Address of Patient
City, State, and Zip Code

Medicare beneficiary identifier
Facility Name
Facility Provider Number
Medical Record Number (if known)
Surgery Date
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review outpatient/ambulatory surgical services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of (insert either "your" or the name of the physician or provider) (date), request for a reconsideration, we have conducted a complete review of your medical record to determine whether our original denial determination was correct.

A QIO physician reviewer denied Medicare payment for your surgery of (date), at (name of provider) for (specify the surgical procedure) because (use the medical information and rationale contained in the initial denial notice).

When we notified you on (date of denial notice) of this denial determination, you were advised that (use the limitation on liability determination and rationale for the beneficiary, provider, and/or practitioner contained in the initial denial notice).

Prior to our reconsideration of this denial determination, we gave your physician, (name), and (name of provider) an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or the provider.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations). Therefore, we have determined that Medicare (select either "will" or "will not") pay for your surgery.

NOTE: If you reverse your initial denial determination, insert: "You will only be responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare."

The physician reviewer also reconsidered the original liability determination that (insert the liable parties, i.e., "you" and/or the name of the provider and/or physician) knew that the denied services were not covered by Medicare. The physician reviewer determined that (Provide the facts and rationale for upholding/reversing the original liability determination for all parties. Include the appropriate statutory and regulatory citations. If your liability determination remains unchanged, tailor the liability language to the limitation on liability information contained in the initial denial notice. If your liability determination changes, tailor the liability language to the appropriate limitation on liability condition found in Exhibit 7-1. Include future liability language).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Use Model Hearings paragraph Exhibit 7-40, Condition I (and Condition II, if appropriate).

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:

Provider
Physician
FI/carrier (if original denial/liability determination changes)

Exhibit 7-49 - Reconsideration Completed Notice -- Continued-stay Denial

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

(Expedited Reconsideration Within Three Working Days)
(Physician Agrees with HINN)

YOUR LETTERHEAD:
Peer System, Inc.
1000 Pine Drive
Baltimore, Maryland 12345
410-555-5555

Date of Notice: August 12, 1990
Name of Patient: John Doe
Address: 200 Cherry Drive
City, State, and Zip Code: Somewhere, MD 00000

Medicare beneficiary identifier: *0000-000-0000*
Provider Name: Nowhere Hospital
Provider Number: 21-0000
Medical Record Number (if known): 2222
Admission Date: August 1, 1990
Physician Name: John Smith, M.D.

Dear Mr. Doe:

The Peer System, Inc., is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of Maryland. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of your August 13, request for an expedited reconsideration, we conducted a complete review of your medical record to determine whether our original denial determination was correct.

You received, with your physician's concurrence, a notice of non-coverage from Nowhere Hospital on August 10, 1990, and requested that we review your hospital stay. A QIO physician reviewer determined that your admission of August 1, 1990, to Nowhere Hospital for medical and surgical treatment of gallstones was medically necessary and appropriate. However, the physician reviewer agreed with your physician and the hospital that beginning August 10, you no longer required acute care in a hospital setting since you were receiving only a medication by mouth. That service, which can be safely provided outside of a hospital, does not constitute a hospital level of care and, therefore, is not covered by Medicare.

On August 12, we notified you that we agreed with Nowhere Hospital's notice of non-coverage and issued a denial determination. You were advised that if you decided to remain in the hospital, beginning 12 noon on August 13, you would be responsible for payment of all costs of the denied services you received, except for those covered services which could be paid for by Medicare Part B.

Prior to our reconsideration of this denial determination, we gave your physician, Dr. Smith, and Nowhere Hospital an opportunity to provide additional information, if they wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in abdominal surgery. The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in your medical record and considered any additional information provided by your physician and/or hospital.

The physician reviewer upheld the original denial determination because services you received beginning August 10 could be given safely and effectively outside of a hospital. The medical records indicate that by that time you were up and about with no assistance, tolerating regular food, required no medication for pain control, and were taking only an oral diuretic in a maintenance dosage. Also, your stitches had been removed, and your incision was well healed and dry. Our authority for denying payment is specified in the Code of Federal Regulations, 42 CFR 473.14(a)(3). Therefore, we have determined that Medicare will not pay the hospital for the inpatient services provided (except for those covered services which can be paid for by Medicare Part B) beginning August 10. Also, the hospital may send you a bill for services provided to you beginning August 10.

The physician reviewer also reconsidered the original liability determination that you are responsible for payment of services you received in the hospital after 12 Noon on August 13, because you knew that the services were not covered by Medicare. The physician reviewer determined that you received adequate notice when you received the August 10 notice of non-coverage from the hospital and our telephone and written notice of August 12. Thus, your liability for the cost of the non-covered services received after 12 Noon on August 13 cannot be waived. Your liability for payment is specified in §1879 of the Social Security Act, and in the Code of Federal Regulations, 42 CFR Part 405.

This reconsideration determination notifies you that the services denied are not covered under Medicare. As you were notified in our August 12 denial notice, beginning 12 Noon on August

13, you became responsible for payment of all costs of services you receive in the hospital except for those covered services which can be paid for by Medicare Part B. For hospital services received prior to 12 Noon on August 13, you are responsible only for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare.

We are also advising your physician and the hospital of this reconsideration determination, which affirms our original denial determination. You should discuss with your physician other arrangements for any further health care you may now require.

Upon receipt of this notice, you will continue to be responsible for payment of denied services occurring in the future which involve the same or reasonably comparable conditions. However, Medicare will pay for all medically necessary and appropriate hospital care you may require in the future.

If you disagree with our reconsideration determination, you may request a formal hearing before an Administrative Law Judge (ALJ) of the Social Security Administration's (SSA's) Office of Hearings and Appeals (OHA) under the following conditions:

- If Medicare has denied payment of $200 or more for services determined to be either not medically necessary or not provided at an appropriate level of care; or

- If you do not appeal the denial of Medicare payment on the medical issues listed above and have been found liable for payment of at least $100 of the denied services, and you disagree with our liability determination that you knew or should have known that the denied services were not covered.

If you do not request an ALJ hearing regarding the liability determination, a dissatisfied provider or practitioner may request an ALJ hearing of that liability determination if they are liable for services of $100 or more.

If you wish to have an ALJ hearing, you must submit a written request within 60 calendar days of receipt of this notice. Your written request should include: your name, Medicare *beneficiary identifier*, where and when services were received, the reason for your dissatisfaction with our determination, any additional evidence you might wish to submit, and a copy of this notice.

You may send your written request to:

- Any social security office;
- An office of SSA's OHA;
- An office of the Railroad Retirement Board, if you are eligible; or
- To us at the following address:

Peer System, Inc.
1000 Pine Drive
Baltimore, Maryland 12345

410-555-5555

(A provider or practitioner may only send a written request to us or OHA.)

If you want help with your appeal of this denial determination, you can have a friend, lawyer, or someone else help you. Some lawyers do not charge unless you win your appeal. There are groups, such as lawyer referral services, that can help you find a lawyer. There are also groups, such as legal aid services, who will give you free legal services if you qualify.

You have the right to examine the complete medical record (and other pertinent information) that we relied upon in making our initial denial and reconsideration determinations. Although the hospital is the official repository of the medical records relevant to stays in the facility, should you wish to examine the records and other pertinent information for this particular stay, contact us at the address or telephone number listed above. There is no charge to examine the material at our office. You may also request a copy of the medical record and other pertinent information. We will, however, charge you a reasonable fee for photocopying and mailing this information.

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you reside along with your complete address and zip code. If you wish the hearing to be held somewhere other than close to your residence, please note that on the hearing request.

Sincerely,

Medical Director

ccs:
Nowhere Hospital
John Smith, M.D.

Exhibit 7-50 - Reconsideration Model Notice -- Circumvention of Prospective Payment System (PPS)

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

(Do not notify the beneficiary or physician)

LETTERHEAD OF THE QIO

Date of Notice
Name of Provider
Address of Provider
City, State, and Zip Code

Patient Name
Medicare beneficiary identifier
Medical Record Number (if known)
First Admission Date
Readmission/Transfer Date
PPS Provider Number
PPS-excluded Provider Number (if applicable)
Physician Name

Dear:

The (your name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review inpatient hospital services provided to Medicare patients in the State of ______________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

As a result of your (date) request for a reconsideration, we have conducted a complete review of the medical record to determine whether our original denial determination was correct.

Select paragraph A, B, or C below:

A: Services Should Have Been Furnished During the First Admission

Our physicians previously reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent acute care readmission of (date) for (specify the procedure/treatment or condition/services). We determined that the services furnished were medically necessary and appropriate. However, the services should have been furnished during the first admission. This action was considered to be a circumvention of the PPS because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital admitted the patient on (date) and again on (date), the hospital received two Medicare payments instead of one. Therefore, we denied Medicare payment for the readmission of (date of 2nd admission).

B: Inappropriate Transfer From a PPS Unit to a PPS-excluded Unit

NOTE: This also applies to similar transfers from a PPS unit to a hospital-based SNF or SNF swing bed.

Our physicians previously reviewed the acute care admission of (date) for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: psychiatric unit, rehabilitation unit, hospital-based Skilled Nursing Facility (SNF), or SNF swing bed) for (specify the procedure/treatment or condition/services). We determined that the patient was admitted to the acute care hospital even though the medical record shows that the patient only required care in the (select: psychiatric unit, rehabilitation unit, hospital-based SNF, or SNF swing bed) and a bed was available at the time of the acute care admission. This action was considered to be a circumvention of the prospective payment system because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we denied Medicare payment for the admission of (date of 2nd admission).

C: Inappropriate Transfer From a PPS-excluded Unit to a PPS Unit

NOTE: This also applies to similar transfers from a PPS-excluded unit to a hospital-based SNF or SNF swing bed.

Our physicians previously reviewed the admission of (date) to the (select: psychiatric or rehabilitation) unit for (specify the procedure/treatment or condition/services) and subsequent admission of (date) to the (select: acute care hospital, hospital-based SNF, or SNF swing bed) for (specify the procedure/treatment or condition/services). We determined that the admission to the (select: psychiatric or rehabilitation) unit was medically necessary and appropriate and that the patient continued to require (select: psychiatric or rehabilitation) care/services when transferred to the (select: acute care hospital, hospital-based SNF, or SNF swing bed). This action was considered to be a circumvention of the PPS because each admission triggered payment for an entire episode of hospital care. Thus, when the hospital discharged the patient on (date) and subsequently admitted the patient on (date), the hospital received two Medicare payments instead of one. Therefore, we denied Medicare payment for the admission of (date of 2nd admission).

This denial determination was based on (use the medical information and rationale contained in the initial denial notice).

Prior to reaching our reconsideration determination, we gave you an opportunity to provide additional information, if you wished.

The reconsideration was performed by a board-certified physician reviewer who specializes in (indicate the specialty of the physician). The physician reviewer, who was not involved in the original denial determination, performed a thorough re-examination of all the information contained in the medical record and considered any additional information provided by the hospital.

The physician reviewer (select either "reversed" or "upheld") the original denial determination because (Provide the facts and rationale for upholding/reversing the original denial determination for all parties. Include the appropriate statutory and regulatory citations.) Therefore, we have

determined that Medicare (select either "will" or "will not") pay for the (insert either "readmission" or "admission") of (date of second admission).

This denial determination is made under §1886(f)(2) of the Social Security Act. This section authorizes a denial of payment under Part A when the Secretary determines, based on information provided by a QIO, that a hospital has taken an action, in order to circumvent PPS, which results in unnecessary admissions, multiple admissions of the same individual, or other inappropriate practices.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

The limitation on liability provision of §1879 of the Act does not apply to Part A denials issued under §1886(f)(2) of the Act. Therefore, the hospital is liable for the charges of the denied services. The beneficiary or his/her representative is only responsible for payment of any applicable amounts for deductible, coinsurance, and convenience services and items normally not covered by Medicare. If the beneficiary or his/her representative has paid the hospital for any of the denied services other than those amounts just mentioned, the hospital is to refund such payment.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

If payment for services is denied due to alleged circumvention of the prospective payment system, you have a right to obtain a hearing conducted by an Administrative Law Judge of the Social Security Administration's (SSA's) Office of Hearings and Appeals (OHA) if the amount in controversy is $100 or more. To do so, submit a written request within 60 calendar days of receipt of this notice. Your written request should include: beneficiary's name, Medicare *beneficiary identifier*, where and when services were provided, the reason for your dissatisfaction with our determination, any additional evidence you may wish to submit, and a copy of this notice.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

The request for a hearing may be sent to:

- An office of SSA's OHA; or
- To us at the following address:

QIO Name
Address
Telephone Number

NOTE: Include the above paragraph only if you uphold your initial denial determination.

If you request a hearing, OHA will notify you of the date and place of the hearing. Hearings are held close to the address given on requests; therefore, if you request a hearing, please include the name of the county in which you are located along with your complete address and zip code. If

you wish the hearing to be held somewhere other than close to your place of business, please note that on the hearing request.

NOTE: Include the above paragraph only if you uphold your initial denial determination.

Sincerely,

Medical Director (or designated physician)

ccs:
FI/carrier (if original denial determination changes)

Exhibit 7-71 - Potential Quality Concern Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

YOUR LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name
Medicare beneficiary identifier
Provider Name
Provider Number
Date of Admission/Service
Medical Record Number (if known)

Dear:

The (QIO name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare patients in the State of _____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our primary purpose is to identify areas where care can be improved and to feed back information to physicians and providers. This peer review is intended to be a collegial interaction with the goal of improving patient care. We appreciate the time and effort involved in your cooperation with our review activities.

A QIO physician reviewer has initially reviewed the care provided to (name of patient) at (name of provider) for (specify the procedure, treatment, condition, and/or services). Based on a careful review of the information contained in the medical record, the physician reviewer has raised some concerns regarding the care provided.

(Summarize the case findings and concerns from the preliminary decision portion of the PRAF.)

This is a potential concern only. We recognize that the medical record may not give a complete clinical picture. Therefore, we are providing you an opportunity to discuss the concerns we have raised prior to rendering our final determination. Your response can be in writing or by telephone. We must receive your response within 20 days from the date of this notice in order for information provided by you to be considered in our final determination. Please direct your response to:

Name of QIO Contact Person
Address
Telephone Number

If you have any questions concerning this notice or would like to make arrangements to discuss this case with a QIO physician reviewer, you may also contact (name of QIO contact person) within 20 days.

We are also notifying (name (See NOTEs below)) of our concerns and offering an opportunity to discuss the concerns we have raised. While the physician and the representative for the provider may respond separately to the opportunity for discussion, we strongly encourage coordination of the responses.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s) also notified.

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify other physicians you may be notifying.

If we do not receive your response by (date), a QIO physician reviewer will make a final determination based on the information contained in the medical record alone.

The information in this notice is confidential and may be re-disclosed only in accordance with Federal regulations found in 42 CFR 476.107 and 108.

Sincerely,

Medical Director (or designated physician)
(Include title)

Exhibit 7-72 - Confirmed Quality Concern Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

YOUR LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name
Medicare beneficiary identifier
Provider Name
Provider Number
Date of Admission/Service
Medical Record Number (if known)

Dear:

The (QIO name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our primary purpose is to identify areas where care can be improved and to feed back information to physicians and providers. This peer review is intended to be a collegial interaction with the goal of improving patient care. We appreciate the time and effort involved in your cooperation with our review activities.

A QIO physician reviewer has completed review of the care provided to (name of patient) at (name of provider) for (specify the procedure, treatment, condition, and/or services). Based on a careful review of the information contained in the medical record and any additional information

provided during the opportunity for discussion, the physician reviewer has reached the following determination.

(Summarize the case findings and concerns, including your preferred course of action, from the initial/final review decision portion of the PRAF.)

We are entering this information into our database for pattern analysis. On an ongoing basis we analyze patterns of care involving quality concerns or positive outcomes that may have significance beyond a single episode. Be assured that if a pattern involving a quality concern is identified, we will provide both you and (name (See NOTEs below)) ample opportunity to discuss the concern with us.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s).

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify any other physicians you may also be notifying.

We are also notifying (name (See NOTEs above)) of our final determination. If you or (name (See NOTEs above)) disagree with our quality of care concern determination, either party may request a re-review. To request a re-review, you must submit your request in writing within 30 days from receipt of this notice. Therefore, we must receive your request by (date). Your written request should include the reason for your dissatisfaction with our determination and any additional information you might wish to submit. Send your written request to:

QIO Name
Address
Telephone Number

The information in this notice is confidential and may be re-disclosed only in accordance with Federal regulations found in 42 CFR 476.107 and 108.

Sincerely,

Medical Director (or designated physician)
(Include title)

Exhibit 7-73 - Re-review Upheld Quality Concern Model Notice

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary

Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

YOUR LETTERHEAD

Date of Notice
Name of Addressee
Address
City, State, and Zip Code

Patient Name
Medicare beneficiary identifier
Provider Name
Provider Number
Date of Admission/Service
Medical Record Number (if known)

Dear:

The (QIO name) is the Quality Improvement Organization (QIO) authorized by the Medicare program to review medical services provided to Medicare patients in the State of ____________________. By law, we review Medicare cases to determine if the services meet medically acceptable standards of care, are medically necessary, and are delivered in the most appropriate setting.

Our primary purpose is to identify areas where care can be improved and to feed back information to physicians and providers. This peer review is intended to be a collegial interaction with the goal of improving patient care. We appreciate the time and effort involved in your cooperation with our review activities.

As a result of a (date) request for a re-review, we have conducted a complete review of the care provided to (name of patient) at (name of provider) for (specify the procedure, treatment, condition, and/or services) to determine whether our original confirmed quality of care concern determination was correct. This re-review was performed by a QIO physician reviewer who was not involved in the original quality concern determination.

Based on a thorough re-examination of all the information contained in the medical record and consideration of any additional information provided by you and the (insert either "provider" or "physician"), the physician reviewer has reached the following determination.

Summarize the case findings and concerns, including your preferred course of action, from the reconsideration/re-review portion of the PRAF (PRAF 3).

We are entering this information into our database for pattern analysis. On an ongoing basis we analyze patterns of care involving quality concerns or positive outcomes that may have significance beyond a single episode. Be assured that if a pattern involving a quality concern is

identified, we will provide both you and (name (See NOTEs below)) ample opportunity to discuss the concern with us.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s).

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify any other physicians you may also be notifying.

The Social Security Act does not provide for further appeal of this determination.

We are also notifying (name (See NOTEs below)) of our re-review determination.

NOTE: If the notice is addressed to the provider, insert the name of the physician(s).

NOTE: If the notice is addressed to the physician, insert the name of the provider. Do not specify any other physicians you may also be notifying.

The information in this notice is confidential and may be re-disclosed only in accordance with Federal regulations found in 42 CFR 476.107 and 108.

Sincerely,

Medical Director (or designated physician)
(Include title)

13110 - QIO Review Documentation

(Rev.32, Issued: 04-12-19, Effective: 05-13-19, Implementation: 05-13-19)

The term Medicare beneficiary identifier (Mbi) is a general term describing a beneficiary's Medicare identification number. For purposes of this manual, Medicare beneficiary identifier references both the Health Insurance Claim Number (HICN) and the Medicare Beneficiary Identifier (MBI) during the new Medicare card transition period and after for certain business areas that will continue to use the HICN as part of their processes.

QIOs shall maintain file records and establish internal control systems that at a minimum enable it to perform the following functions as required under the contract:

- Provide an accurate and complete record of all in-progress and completed activities, correspondence, and analyses, including a record of times and dates, in connection with every individual case review effort

- Identify all individuals, roles, responsibilities, and determinations made as part of every individual case review effort

- Identify all quality improvement activities in-progress and completed, to include provider/practitioner improvement plans and points of contact for each quality improvement activity

- Furnish complete and accurate documentation to CMS and authorized third parties upon request

- Comply with requirements for protection of all data and records in accordance with CMS security and privacy policies (see QIO Manual Chapters 8 and 10, and 42 CFR Part 480) and procedures identified in the QIO contract

- Transfer to CMS, or to a successor QIO contractor as directed by CMS, any records and files, including patient medical records, necessary to perform the business functions of the QIO that are identified in the QIO contract

Case Review Documentation Requirements

At a minimum, QIO case review documentation must include:

- Case identifiers (e.g., *Medicare beneficiary identifier*)

- Determinations (outcomes) of each review (e.g., approval, denial, coding decision, quality concern)

- Medical review criteria used in the review

- Verification that appropriate review was performed

- Name and title of each reviewer who contributed to the determination (e.g., review coordinator, physician advisor)

- Dates of each review function that demonstrate compliance with review timeframes (e.g., date case was identified for review, dates records requested and received, dates review initiated and completed, dates notices issued, if applicable)

- Any referrals to other QIOs or external agencies

Denial Determinations, Diagnostic Related Group (DRG) Assignment Changes, and Confirmed Quality Concerns

If the QIO determination results in an initial or technical denial, DRG assignment change, or confirmed quality concern, the review documentation must also include:

- The detailed basis (e.g., all documentation already in your possession for the case) for the denial determination (including limitation on liability determinations and documentation errors), DRG assignment change, or confirmed quality concern

- A copy of the notice that was sent to all parties, identification of each party, and the date the notice was mailed or delivered

- The returned envelope and notice, if the notice was subsequently returned as undeliverable or receipt refused

Reconsideration and/or Provider Request for a Review of a QIO DRG Determination

If the QIO conducts a reconsideration or review of the QIO DRG determination, its review documentation must also include:

- Documentation of the reconsideration or review request

- The detailed basis for the reconsideration (including the limitation on liability determination) or review determination

- A copy of the reconsideration or review determination letter that was sent to all parties, identification of each party, and the date on which the notice was mailed or delivered

- The returned envelope and notice, if the notice was subsequently returned as undeliverable or receipt refused

Format of QIO Case Review Documentation

QIOs shall retain case review documentation in an easily retrievable format such as hard copy, electronic file record, or as specified in its contract.